DENTAL FORM (Consent for Exam)

CHILD'S NAME:_____

DENTAL HISTORY

1. **Has your child previously seen a dentist? ___yes ___no**
   If yes, a) Name of dentist: _____
   b) When was last visit?_____
2. **List any dental problems that your child has experienced._____**
   _____
3. **Does your home have: ___city water ___well water ___other_____**
4. **Name of your child's physician: _____**
5. **Is your child currently taking any medications? ___yes ___no**
6. **Has your child ever had any of the following:**

Allergies ___yes ___no		**Epilepsy**	**___yes ___no**
If yes, please list: _____		**Heart/blood**	
_____		**vessel disease**	**___yes ___no**
Asthma ___yes ___no		**Liver disease**	**___yes ___no**
Bleeding ___yes ___no		**Rheumatic fever**	**___yes ___no**
Diabetes ___yes ___no		**Sickle cell disease**	**___yes ___no**

   Other diseases_____
7. **Are you aware of any other health problems with your child? _____**
   _____
8. **Does your child have any of the following?**
   ___ TennCare card number_____MCO_____
   ___ Private dental insurance-company _____Group no._____
9. **I hereby grant my permission for information on this form to be given to the dentist.**
   a. ___yes ___no
10. **Date_____Parent/guardian_____**

Plan for dental exam or obtaining documentation of current exam

Please check one of the four following plans after discussing with parent. Reminder:
Dental exam must be completed within 90 calender days of enrollment.

1. **____The child has had a dental exam within the last year. Get a *Verification of Dental Exam/Treatment form* signed. Remind parent a yearly exam will be due when the year expires.**
2. **____The child's parent will make an appointment with Dr. _____ for a dental exam.**
3. **____The child will be examined by the Health Department dentist who will do exam in the classroom. (Parent must sign this permission.)**
   I give my consent for my child to have his/her teeth and mouth examined by a dentist from the public health department who will come to the classroom and do the exam.
   Parent/Guardian signature_____Date_____
4. **____The child will be transported to a dental office by Head Start staff, without the parent present, for an exam. (Parent must sign this permission.)**
   I give my consent for my child to be transported by Head Start staff, in my absence, to have his/her teeth and mouth examined by the following dentist, Dr._____.
   I understand that x-rays may be taken and that cleaning and fluoride may also be done at this appointment.

   Parent signature_____ Date_____