# PARENT CONSENT FOR PUBLIC HEALTH HYGIENE SERVICES

NORTH DAKOTA DEPARTMENT OF HEALTH
ORAL HEALTH PROGRAM
SFN 61754 (12-2019)

| Name of Child (First, Middle, Legal Last) | Age |
|---|---|
| Name of Clinic | |

☐ YES, I give my permission for my child to receive the following treatments:

- ☐ Oral Screening
- ☐ Sealants
- ☐ Fluoride Varnish

☐ NO, I do not give my permission for my child to receive treatment. Specify reason:

- ☐ My child already has sealants and/or receives varnish.
- ☐ My child regularly sees a dentist.
- ☐ Other (describe): _____

** If you checked no, you do not need to complete the rest of the form.*

If you answered yes to the above, complete the rest of the form.

| Name of Parent/Guardian | | | Preferred Telephone Number |
|---|---|---|---|
| Address | City | State | ZIP Code |
| Email Address | Child's Date of Birth (MM/DD/YYYY) | Gender ☐ Male ☐ Female | Primary Language |

Race of Child (check one)

☐ White ☐ Black/African American ☐ Multi-racial ☐ Declined to Answer
☐ Asian ☐ American Indian/Alaskan ☐ Other

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Is your child allergic to anything? If yes, what? |
| ☐ | ☐ | Is your child taking any medications? If yes, what? |
| ☐ | ☐ | Does your child have any medical conditions such as heart disease, asthma, hay fever, hepatitis, cancer, diabetes, etc.? Or any other medical condition? If yes, specify: |
| ☐ | ☐ | Has your child ever needed dental services but was unable to receive services or denied services? If yes, explain: |
| ☐ | ☐ | Does your child have a dentist? If yes, answer below: |

| Name of Child's Dentist | Date of Last Visit ☐ Within the last 6 months ☐ More than one year ago ☐ Never |
|---|---|

☐ My child has no dental insurance

Medicaid Number (if child has Medicaid) - Medicaid insurance will be billed. No family or child will receive a bill for services provided.

| Signature of Parent/Guardian | Date |
|---|---|

*By signing above, indicates that you have read and understand the contents of the general information and medical history form. You understand the terms of the consent agreement and that you have legal authority to give consent for this child. Your child's personal information will be kept confidential and will not be shared with any person who is not directly involved in the care of your child as part of the Health Insurance Portability and Accountability Act (HIPAA) without written authorization."*