



**** The parent/guardian must complete this entire page.**



PARENTAL PERMISSION SLIP For Fluoride Varnish and Sealants. Please check all that apply:

 YES I give permission for my child to participate in the **Fluoride Varnish Program**. I *also* give permission for my child to receive **Dental screening and to receive dental Sealants** if necessary and I understand this service is available only to children who do not have access to this preventive service and that my child will also receive a dental cleaning and fluoride as part of the dental sealant process. I authorize the UMass Memorial Ronald McDonald Care Mobile staff to release information regarding treatment for purposes of billing for services but I understand that services are free to me.

 YES I give permission for my child to participate in the **Fluoride Varnish Program**.

 NO I do **NOT** wish for my child to participate in the **Fluoride Varnish or Sealant Program**.

Child's Information

Name _____ Date of birth _____ Race: _____ Sex: M/F
Grade _____ Teacher _____ School: **Chandler Elementary School**
Home Address _____ Zip _____ Phone _____
Social Security number _____
Name/address of Primary care physician _____ Last Visit Date _____
Does the child have health insurance? Yes ___ No ___ If yes please answer the questions below:
Name of insurer _____
Policy number/MassHealth card number _____
Does the child have dental insurance? Yes ___ No ___ If yes, name of insurer _____
Name/Address of Child's Dentist _____ Last Visit Date _____

Parent/Guardian information:

Name _____ Parent/Guardian daytime telephone _____
Signature of Parent/Guardian _____ Date _____

ALL MEDICAL INFORMATION MUST BE COMPLETED

1. Is child in good health? _____ YES _____ NO
2. Is child under a physician's care now? _____ YES _____ NO
If so, please explain: _____
3. Is child taking any medication at this time? _____ YES _____ NO
If so, please list medications: _____
4. Please circle any illnesses or conditions your child has EVER had:

Tuberculosis	Anemia	Kidney/Liver	Rheumatic Fever	Diabetes
Heart Murmur	Heart Problems	Food Allergy	Asthma	Hepatitis
Epilepsy	Glaucoma	Seizures	Convulsions	Immune Disorders

 Other health problems: _____
5. Is your child allergic to Latex? ___ YES ___ NO List other allergies: _____
6. Has your child ever had prolonged bleeding after surgery? _____ YES _____ NO
7. Is there any other information that should be known about your child's health? _____ YES _____ NO
If so, please list: _____

Please check one of the following:

 I need help finding a dentist for my child. I prefer (circle one) Family Health Clinic, Great Brook Valley, QCC Children's Dental Program. Forward my child's information to that location and call me to schedule an appointment.
 My child is seen (how often?) _____ for cleanings and examinations. I would prefer to arrange dental follow-up for my child.

I hereby acknowledge that I have received a copy of the UMass Memorial Medical Center's Joint Notice of Information Practices (the Notice). I understand that the Notice describes how the medical center uses and discloses my medical and billing information. The Notice also describes my rights and how I can receive additional information.

Signature of Parent/Guardian _____ **Date** _____