



Kern County Children's Dental Health Network (East Kern)

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# DENTAL CONSENT FORM

Name of Student \_\_\_\_\_ <sup>please circle:</sup> Male or Female Date of Birth \_\_\_\_\_

Teacher/Rm# \_\_\_\_\_

Race: (please circle) Black/African American White/Caucasian Hispanic/Latino Mexican/Mexican-American/Chicano Central American  
 Puerto Rican Cuban Alaskan Native/American Indian Asian Indian Chinese Filipino Japanese  
 Korean Vietnamese Other Asian Native Hawaiian Guamanian/Chimarro Samoan  
 Other Pacific Islander More than one ethnicity/multi-racial Other \_\_\_\_\_

A comprehensive dental program will be available for your child at your child's school. The program will offer services that will give you and your child a better understanding of oral hygiene and provide treatment services to help stop tooth decay. The services your child will receive are:

**Screening of Teeth**

A dentist will examine and re-examine your child's teeth using dental examination instruments. **No x-rays** (radiographs) will be taken.

**Dental Cleaning and Fluoride Application**

Students who are in need of a professional cleaning will have their teeth cleaned and fluoride applied by a registered dental hygienist.

**Sealant Application (for kindergartners only)**

Dental decay usually begins in the grooves of the back permanent teeth (usually these teeth erupt around 6 years of age). A dental sealant is a white liquid that is painted in the groove and hardens to prevent or seal out decay. After the dentist decides which teeth need sealing, the teeth are cleaned and the sealant liquid is painted in the grooves. It hardens in one minute protecting the teeth from decay. Sealants can last five years or more but should be checked by a dentist during **regular check ups**.

I have read and understand the dental services offered by the Kern County Children's Dental Health Network. This student has my permission to receive all appropriate dental services and all necessary care offered by the program. I understand the services will be provided by a licensed dentist, registered dental hygienist or dental assistant practicing under the laws of the State of California.

I also understand that the examination results are confidential and kept according to the policies of the school and state and federal law. I **UNDERSTAND THERE IS NO COST FOR THESE SERVICES**, however, Medi-Cal/Denti-Cal/Healthy Families/Healthy Kids may be billed to help cover the cost of the program.

Please **circle** if your child has: Medi-Cal/Denti-Cal Healthy Families Healthy Kids Other Dental Insurance NONE

**Yes No** - I would like more information on **no/low cost health & dental insurance for my child**.

A representative from Kern Access to Children's Health Program can contact me.

I authorize the dental program to release information regarding services provided to Medi-Cal/Denti-Cal, Healthy Families or Healthy Kids for billing purposes. My child's insurance # \_\_\_\_\_

My child's date of birth is: \_\_\_\_\_ My child's Social Security # \_\_\_\_\_

My telephone # is \_\_\_\_\_ Has your child been to a dentist before?  YES  NO

**YES**, I want my child to participate  **No**, I do not want my child to participate

\_\_\_\_\_  
Print name of parent

\_\_\_\_\_  
Signature of parent

\_\_\_\_\_  
Date

