******* *PERMISSION FORM FOR DENTAL SERVICES AT SCHOOL* *******

PARENT or GUARDIAN CONSENT

HARTFORD PUBLIC SCHOOLS DENTAL PROGRAM

Dear Parent/Guardian:

The school Dental Office can provide the following services in our school, during school hours: **x-rays, cleanings, topical fluoride treatments, sealants, fillings, extractions, root canals, space maintainers, stainless steel crowns, emergency dental treatment, and dental health education.** Local anesthesia (i.e. Novocaine) will be used.

If you wish your child to receive dental treatment at school, please answer all the questions and sign the form. Return this form to the school dental office. You are welcome to visit the dental office with your child.

CHILD'S NAME_____ RM_____ BIRTHDATE_____

PARENT/GUARDIAN_____ ADDRESS_____

PHONE_____ WK #_____ CELL #_____ BEEPER_____

EMERGENCY CONTACT_____ PHONE_____

CHILD'S NAME ON MEDICAL CARD/INSURANCE_____

CHILD'S MEDICAID/HUSKY NUMBER (#) _____ PLAN_____

CHILD'S SOCIAL SECURITY NUMBER (#)_____

MEDICAL HISTORY

Name of medical doctor or clinic where child gets care_____

Does your child have any of the following?	CHECK YES/NO		Explain "Yes" answers:
Heart Condition?……	Y ☐	N ☐	_____
Heart Murmur?……..	Y ☐	N ☐	_____
Allergies?……	Y ☐	N ☐	_____
To medications?……	Y ☐	N ☐	_____
To balloons or other latex materials?……..	Y ☐	N ☐	_____
Asthma?……..	Y ☐	N ☐	_____
Seizures?……	Y ☐	N ☐	_____
Any infectious diseases?……..	Y ☐	N ☐	_____
Sickle Cell Anemia?……..….	Y ☐	N ☐	_____
Sickle Cell Trait?……	Y ☐	N ☐	_____
Problem with bleeding?……	Y ☐	N ☐	_____
Any other medical problem not listed?……..	Y ☐	N ☐	What?_____
Does your child take any medications?……..	Y ☐	N ☐	What?_____
When was your child's last visit to a dentist? _____			Who? _____

Please let the dental office know if there are any changes in the above information.

PERMISSION FOR TREATMENT

You have my permission to do the dental work my child needs. The dentist will use local anesthesia (i.e. Novocaine) if it is needed. *I also give permission to release information regarding treatment and/or services to insurance providers for the purpose of billing, and authorize payments to be made directly to the Hartford Public Schools, Health Services Department for services provided.*

SIGNATURE _____ DATE _____

Parent/Guardian

The Hartford Public Schools Dental Offices are open during regular school hours by appointment. For after-hours treatment of emergencies, you will need to call your health insurance carrier concerning treatment options or in case of emergency please seek treatment at a nearby hospital emergency room.

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