Miles of Smiles
Mobile Dental Unit

miOttawa Department of Public Health

If your child has a dentist, please DO NOT complete this form

Please complete and return to your child's school IMMEDIATELY

Please print clearly

School Name: ________________________ Grade:________ Teacher: ________________________

Child's Name:________________________ Gender: ________ Date of Birth ____/_____/______

First MI Last

Parent's Name: ________________________ Phone: (_____) ______- ___________

Address:________________________ Cell Phone: (_____) ______-___________

Street, Lot # or Apt. # City Zip

Email: ________________________ Child of Migrant Farm Worker: Yes / No

Ethnic/Racial Background: *(circle all that apply)* African American Arab/Chaldean Asian/Pacific Islander Hispanic Native American White/Caucasian

To receive dental services this portion must be completed:

If dental services are obtained elsewhere; it may affect benefits that your child receives from private insurance, a state or federal program, or a third party provider.

Child's Medicaid/Healthy Kids Dental ID#:________________________ Child's Social Security # ________________________

How many people are in your household?______________ What is your **monthly** household income before taxes? $___________________

HEALTH HISTORY

Are immunizations complete? Yes / No Date of last dental exam:______________ Dentist or dental office that previously provided dental services in the past 12 months: ________________________

Please check ✓ each condition that applies to your child

	Acid Reflux/GERD		Heart Disease
	ADD/ADHD		Heart Murmur
	Anemia		Hepatitis/Liver Disease
	Artificial Joints		HIV/AIDS
	Asthma		Kidney, Bladder Disease
	Autism		Pacemaker/Implanted Devices
	Bleeding disorders		Pregnant, Nursing
	Cerebral Palsy		Psychiatric/Psychological Care
	Chronic Sinus		Radiation/Chemo Treatments
	Congenital heart Disease/Defect		Rheumatic Fever
	Convulsions		Seizures
	Dental Surgery - Date:________		Steroid Therapy
	Diabetes		Taking Birth Control
	Disability		TB/Emphysema
	Epilepsy		Thyroid
	Hearing		Tumors, Cancer
	Heart Attack or Stroke		Other:_________________

	Yes	No
Is your child under the care of a doctor for any medical condition? If yes, what medical condition?	☐	☐
Is your child taking any medications? If yes, medication and reason for taking them:	☐	☐
Has your child been hospitalized? Please list why and when:	☐	☐
Does your child have any allergies to drugs, foods or latex? Please list:	☐	☐
Does your child have any cognitive/emotional impairments? If yes, please explain:	☐	☐
Does your child take a pre-medication for dental procedures? If yes, what?	☐	☐
Please provide any additional details on your child's health:		

I hereby grant Ottawa County Department of Public Health (OCDPH) permission to perform all dental services on my child, including the use of Nitrous Oxide, x-rays, prophylaxis (cleaning) sealants, fluoride, fillings, pulpotomy (baby tooth nerve treatment), stainless steel crown or extractions. I also grant permission for dental, dental hygiene and/or dental assisting students, under the direct supervision of a licensed dental professional, to provide dental services for my child. I understand that an HIV or hepatitis test may be performed on him or her without consent in the event that an OCDPH employee or a dental provider sustains a needle stick injury, mucous membrane or open wound exposure to my child's blood or other body fluids. In the event of an emergency I authorize an adult to seek medical attention for my child. I give permission for a school employee to transport my child to OCDPH's designated medical facility.

This consent is good for one year from date of signature. I certify that the above information is true and correct to the best of my knowledge. I hereby authorize OCDPH to verify the information above. **Please inform us of any Medical history changes by calling 800-467-5905**. I understand that if I have given false information this may disqualify my child from receiving dental services. I certify that I give full consent to have my child photographed, videotaped and/or interviewed on Miles of Smiles dental mobile unit. I also give full consent for said photographs, videotapes and/or interviews to be published for health agencies use and/or news media releases. Dental records may be made available to schools, Head Start programs, dental offices, clinics, health agencies, assistance programs and your health insurance plan, upon request. I have been informed that the HIPAA Privacy Notice is available on the county website www.miottawa.org/dental. A copy of the HIPAA Privacy Notice is also available upon request by calling **616.494.5540**

________________________ ________________________ ________________________

Signature of parent or legal guardian *Relationship* *Date*