Office Use Only: Teacher Name: _____ Grade: _____

2025 - 2026 School Dental Care Consent Form

Child's Last Name:_____First Name:_____ M.I.___

Birth Date:_____ ( ) Male / ( ) Female Tribal affiliation: _____

Home Phone:_____ Cell Phone: _____

Address: _____ City/ Zip Code: _____

Parent E-mail Address: _____

Emergency Contact Person and Phone #:

Medical History: Check all that apply ( ) Anemia ( ) Asthma ( ) Bleeding problems ( ) Diabetes
( ) HIV+ ( ) Heart condition ( ) Hepatitis ( ) Latex Allergy ( ) Rheumatic Fever ( ) Seizures
( ) Tuberculosis ( ) Other: _____

List medication(s) currently being taken: _____

Has your child had any serious illnesses, injuries or operations? _____

Does your child have any allergies? _____

Is there any other information we should know about your child's health or special needs? No _____Yes _____

_____

Dental Insurance: ( ) Dental Insurance : Insurance Company Name: _____
( ) No Insurance ( ) Medical Assistance / BadgerCare

Please read carefully:

_____ **No, I do not want my child to participate in the Dental Prevention Program at Oneida Nation Schools.**

_____ Yes, I give consent for my child to participate in the Dental Prevention Program to be conducted by the Oneida Community Health Center Dental Clinic.

_____ Yes, I have answered the medical history questions on this form correctly and completely, to the best of my knowledge.

_____ Yes, I give permission for my child to receive any preventive and diagnostic treatment, including an examination, x-rays films, dental cleaning, fluoride treatment and sealants as deemed necessary by the OCHC dental staff.

_____ Yes, I agree to seek any follow-up care my child may need from the OCHC Dental Clinic or a dentist of my choice.

_____ Yes, I understand I will not receive a bill for any dental services provided by the dental Prevention Program at Oneida Nation School, however, the OCHC will bill my insurance, if applicable.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Name (print) Phone #