Parental Consent & Registration, Health History & Consent Form

Child's Information (*only one form per child*)

First Name _____ Last Name _____

Date of Birth (mm/dd/yy) _____ ☐ M ☐ F Dental Insurance (if any) _____

Address _____ City _____ State _____ Zip_____

Daytime Phone _____ Cell Phone _____

Emergency Contact _____ Phone _____

Child's Health History

Circle the appropriate answer:

- Is a physician treating your child? **YES NO**
  If yes, why?_____
- Has your child been a patient in a hospital? **YES NO**
  If yes, why?_____
- Does your child have any allergies? **YES NO**
  If yes, what? _____
- Does your child take medications? **YES NO**
  If yes, what? _____
- Is there anything else we should know about your child?
  _____
  _____
- Has your child been seen by a dentist before? **YES NO**
  Please explain: _____
  _____
- Has your child ever received dental x-rays or radiation therapy? YES NO
  When? _____

Circle all that apply:

Asthma **YES NO**

Heart Murmur **YES NO**

Diabetes **YES NO**

Seizures **YES NO**

HIV/AIDS **YES NO**

Heart Disease **YES NO**

Bleeding Problems **YES NO**

Please explain:
_____

Have you already been to a Give Kids A Smile screening?
_____ **YES NO**_____

I give permission to have my child's photo taken for publications, promotional purposes, website, media press release on behalf of Give Kids A Smile **YES NO**

PARENT/GUARDIAN SIGNATURE

I certify that I have read and understood the above questions. The information that I have provided is correct to the best of my knowledge. I will not hold the New Jersey Dental Association, New Jersey Dental School or any other participating sites of the *Give Kids A Smile!* program or any member of the staff responsible for any errors or omissions I have made in the completion of this form. I also authorize the doctors, dental staff and dental students to perform the necessary dental services that my child may need including, but not limited to, cleanings, fluoride, sealants, x-rays, anesthesia, pulpotomies, extractions, and fillings.

NAME OF PARENT/GUARDIAN: _____

SIGNATURE: _____ **DATE:** _____