

Dental Services at School!

Return by: _____ School: _____
 Child's name: _____
 Teacher's name: _____ Room#: _____ Grade: _____



OAKLAND UNIFIED SCHOOL DISTRICT
 Community Schools, Thriving Students



NATIVE AMERICAN HEALTH CENTER
 Serving the community since 1972



LifeLong Medical Care
 Health Services for All Ages



About the dental program:

This dental program is supported by OUSD and Alameda County Office of Dental Health.

- All students are eligible to receive dental services at no cost, regardless of insurance or legal status. We can bill Medi-Cal or provide the same services free of charge to students with no insurance.
- All dental services are performed by licensed dental providers at the school. Your child will not miss any school days.
- You can choose what dental services you want your child to receive: dental exams, preventive services, and some dental treatments are available at school. In some cases, students may also be referred to a dental clinic.

How to get this dental care for your child:

To give your permission, please complete this consent form and return it to the school as soon as possible. Information on privacy practices, policies, and procedures are available at the school office and/or clinic.

My child will NOT participate in this dental program

1. First tell us about you (parent/guardian)

Your first name: _____ Last name: _____

Are you the: Mother Father Other: _____

Your phone number: () _____ Cell phone: () _____

Your date of birth: month: _____ day: _____ year: _____

Your street address: _____ Apt. # _____

City: _____ Zip: _____

Language spoken at home: _____

2. Now tell us about the child who will receive dental care

(You must fill out a form for each child receiving dental care)

Child's first name: _____ Last name: _____

Child's gender/sex: _____

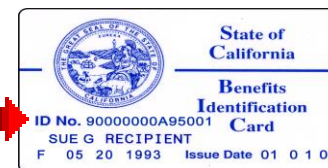
Child's date of birth: month: _____ day: _____ year: _____

Is this child: Hispanic/Latino African American White
 Native American Pacific Islander Asian
 Multi-racial Other: _____ Decline to answer

3. Insurance information

What type of insurance does your child have?

- No insurance at this time**
- Medi-Cal** → please provide the Medi-Cal ID # _____
 on the card: _____
- HealthPAC** **Other public insurance** **Private insurance**



4. Does this child have a dentist?

- Yes** → Name of dentist or clinic _____
- No**

When was the child's last visit to the dentist?

- Less than 6 months ago 6 months to 1 year ago
 More than 1 year ago Never been to the dentist

5. Is this child currently taking any medications?

This includes prescription medications and medications you can get without a prescription from the doctor.

- No medications**
- Yes** → Please list the **name** and **purpose** of each medication:

Please fill out the front & back side of this form



