



*Spanish Available

The Dental Van is Coming to Your Childs School

- NO COST Dental Exams and Cleanings
- Minimal Time Away From Classroom
- Fulfills Illinois State Dental Exam Requirement
- Parents are Always Welcome to Accompany Children

To Participate: Fill out the attached consent form, check “YES”, sign, and return form to school

Mobile Care Chicago is a non-profit organization dedicated to helping kids receive the best quality health care. Our goal is to be a convenient resource in neighborhoods with few alternative resources. All services are provided at no cost to families. For more information, visit us at www.mobilecarechicago.org or call us at 773-254-4030!

Mobile Care Chicago Dental Consent Form 312-543-5693

SCHOOL: _____

Teacher: _____ Grade _____

State law requires us to obtain your consent to your child's contemplated dental treatment or oral surgery. **Please read this form and ask about anything that you do not understand.** We will be pleased to explain it. I hereby authorize and direct Mobile Care Chicago dentists and/or dental auxiliaries to perform upon my child (or legal ward for whom I am empowered to consent) the following checked dental treatment or oral surgery procedure(s):

Yes, I would like for my child to receive **ALL SERVICES** offered at his/her school this includes dental exam, radiographs (x-rays), prophylaxis (cleaning), application of fluoride, and application of sealants.

No, my child receives regular dental care. I do not wish for my child to participate in the program (We encourage you to stay with your family dentist if you have one.)

Yes No to photograph and/or videotape of my child during visits for corporate literature and medical, scientific, or educational purposes, provided my child identity is not revealed.

Patient Information

Child's FULL Legal Name _____
First Name Middle Name Last Name

Sex: Male Female Age _____ Birth Date _____

Do you have legal custody of this child? Yes No **If NO, STOP!**
Forms must be completed by parent or legal guardian

Parent/Guardian's Name _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Does your child have Medicaid/All Kids? Yes No If Yes, ID Number _____

Dental History

Has your child ever been to a dentist? Yes No

Does your child have a family dentist? Yes No If yes, Dentist's Name and City _____

Has child been seen in the last 12 months? Yes No If yes, when _____

What services were performed? _____

Does your child have any dental problems/complaints?

Has your child been informed by a physician due to a medical condition that he/she needs to take an antibiotic before their dental treatment? Yes No If Yes, please explain _____

Medical History

Child's Doctor _____ City/State _____ Phone _____

Is child under the care of a doctor now? Yes No Ever been hospitalized Yes No

If yes, please explain _____ If yes, please explain _____

Is child receiving any medication? Yes No Ever had surgery? Yes No If yes, why? _____

If yes, list current medications, including over-the-counter and herbal: _____

Is your child allergic to any foods, medications, environmental allergens, or other? Yes No

Please list known allergies _____

HAS CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CIRCLE

AIDS/HIV	Cerebral Palsy	Heart Murmur	Mental Health	Tumors/Growths
ADD/ADHD	Cognitive Disorders	Heart Disease	Pregnancy	Mental Disorders
Anemia	Communication Disorders	Hemophilia	Respiratory Care/Disease	Hearing Problems
Artificial Heart Valves	Developmental Disability	Hepatitis	Rheumatic Fever	Cancer
Asthma	Diabetes	Implants	Rheumatism/Arthritis	Tuberculosis
Behavioral Disorders	Donor Organs	Intestinal Disease	Seizures	Blood Transfusion
Blood Disorders/Disease	Drug/Alcohol Abuse	Joint Replacement	Sexually Transmitted Diseases	Liver Disorder/Disease
Blood Pressure High	Emotional Disorders	Kidney Disease	Sickle Cell Anemia	Fainting/ Dizzy Spells
Blood Pressure Low	Epilepsy	LATEX ALLERGY	Stomach Disease	

Other: _____

Emergency Information

In the event of an emergency, whom should we contact (other than yourself)?

Name _____ Relationship _____ Phone _____

Consent and Authorization

Although their occurrence is not frequent, some risk and complications are known to be associated with dental or oral surgery procedures. The most common complications associated with pediatric dental treatment include nausea following the administration of topical fluoride and children biting and injuring their tongue or lip following the administration of local anesthesia. Less complications include the risk of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown from an extracted tooth or gauze packing; injury to the tongue and/or lips, damage to and possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root which may require additional surgery for its removal. For children with heart disease, the risk of sub-acute bacterial endocarditis (head infection) following dental treatment exists; therefore antibiotics will be prescribed before and following treatment, to minimize the risk.

I hereby state that I have read and understand this consent form, that I have been given opportunity to ask questions I might have and that all questions about the procedure(s) have been answered in a satisfactory manner and I understand further that I have the right to be provided with answers to questions which may arise during the course of my child's treatment. By signing this form I consent and authorize the doctors of Mobile CARE Foundation to furnish dental treatment on my child.

Signature of Parent/Guardian _____ Date _____

THIS CONSENT IS VALID FOR A PERIOD OF ONE YEAR FROM DATE OF SIGNING