Give Kids a Smile Ohio
HEALTH HISTORY AND CONSENT FORM

ADA Foundation®

The following health history and consent form must be filled out in its entirety, both front and back, by the parent or guardian.

Please tailor the form to your particular program logistics and event. A Word version of this document is available upon request by contacting kristy@oda.org.

NOTE TO DENTISTS: The following form includes sample consent/release language, which may be utilized on GKAS Health History and Permission forms. This form is intended to offer general guidance but should not be construed as legal advice and cannot be substituted for the advice of the dentist's own legal counsel. Consent/release language used will depend on type of event conducted during GKAS. Please review carefully and consult with your attorney prior to use.

For events that are not providing restorative or follow-up care, a list of safety net dental clinics is posted on the Ohio Department of Health's website at: http://www.odh.ohio.gov/odhprograms/ohs/dsnc/Dental-Safety-Net-Clinics.aspx – you can print out the 2-page brochure under "How can I find dental safety net clinics in Ohio?" or make the link available for parents.

Do not take pictures of a child undergoing treatment without a signed consent form from the parent or guardian (see sample below). You do not need to concern yourself with media photographers. They will handle photo releases on behalf of their media outlets.

For clinical photos where a patient is in a dental chair, please be sure that the dental team members are wearing appropriate gloves, masks, and protective eyewear, and wristwatches are removed, even if care is not being provided at that particular moment. Long sleeved scrubs or disposable gowns are preferred. Thank you.

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Date: _____

First _____ MI ___ Last _____

Date of Birth _____ Gender _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Emergency Contact (Name and Phone Number):

_____

_____

Pediatrician/family physician name and phone number: _____

_____

Does your child have or has your child had:

Asthma	Y	N	Congenital heart disease	Y	N
Heart Murmur	Y	N	Rheumatic heart disease	Y	N
Diabetes	Y	N	Bleeding problems	Y	N
Seizures	Y	N			

Is your child taking any medications? Y N
What medications? _____

_____

Does your child have any allergies? Y N
If Yes, what allergies? _____

_____

Has your child had any other serious illness or operation? Y N
If Yes, what illness or operation? _____

_____

Does your child have health insurance coverage? Y N

Is there anything else we should know about the health of your child? List:

_____

_____

_____

(continued on back)

Give Kids a Smile Ohio

Date: _____

I give consent for my child, _____ (please print) to participate in the dentistry program conducted through Ohio's Give Kids a Smile. To the best of my knowledge, the medical history questions have been answered correctly and accurately. I allow my child to have an oral examination, and dental procedures necessary to properly diagnose and treat any dental problems.

I understand that, because of the number of people needing to be seen, my child might not receive care. I understand that my child might have certain medical conditions which would keep him or her from having dental treatment. I also understand that the dental care providers are volunteers, some from out-of-town and may not be available for follow-up care in the event of complications.

If your child should have an emergency after treatment, call phone number [PHONE NUMBER] until [DATE (RECOMMENDED AT LEAST 30 DAYS)]. I understand that this number will not handle emergencies after that date and I agree to seek any follow-up care I might need from my local dentist, health department, family physician or a hospital emergency room. Acceptance of your child as a patient will be based upon availability of services.

I grant to the Give Kids a Smile Ohio programs, [ORGANIZATION/PRACTICE NAME], the Ohio Dental Association, the ADA Foundation, and the American Dental Association (collectively, the "organizations" and individually, an "organization"), to take photographs, digital images, video or voice recordings of my minor child at the above-identified event. I hereby authorize the organizations to use, reuse, reproduce, publish, or republish any photographs, recordings, or any other record of my child's participation in this event, in any medium now known or hereafter developed, alone or in conjunction with other material, without restriction as to changes or alterations, as well as to use my child's name, voice, likeness, and/or other indicia of identity, for editorial, educational, promotional, or advertising purposes, including without limitation in connection with the solicitation of contributions and the furtherance of the objectives of Give Kids A Smile. I authorize use of the images without compensation to me. All negatives, prints, digital reproductions shall be the property of the organization taking the image.

In consideration of any of the activities and free oral health care services received on [DATE], or any other date(s) of GKAS, I, or myself and anyone entitled to claim through me, do hereby waive and release from liability any persons or volunteers associated with this event and the following groups and the officers, directors, employees, affiliates and/or assigns of the following groups: the American Dental Association, the Ohio Dental Association, the [LOCAL DENTAL SOCIETY NAME], [ORGANIZATION/PRACTICE NAME] and any other named or unnamed sponsors, sites or persons associated with this event.

Name of Parent/Guardian (Printed) _____

_____

Signature

_____

Date

Give Kids a Smile Ohio
PATIENT REPORT FORM TO PARENT/GUARDIAN

Patient name: _____ Date: _____

Site seen: _____ Seen by: _____

The following services marked with an "X" were provided to your child during Give Kids a Smile at no cost.

_____ Examination
_____ X-rays
_____ Oral hygiene instructions
_____ Tooth brush, floss and supplies
_____ Dental prophylaxis (professional cleaning)
_____ Professional fluoride treatment
_____ Restorations (fillings)
_____ Extractions
_____ Sealants
_____ Other services: _____

Total free treatment value: $_____

Your child is in need of further dental care. Yes No

Other treatment needed: _____

_____

If your child should have an emergency after treatment, call telephone number [PHONE NUMBER (SAME AS PREVIOUS PAGE)] until [DATE (SAME AS PREVIOUS PAGE)] or your local dental society. This number will not handle emergencies after that date. Thank you again for allowing your child to participate in this very important process for good oral health.