|  |  |  |
| --- | --- | --- |
| Child’s Name: | Age: | Date of Birth: |
| Address: | Cell Phone:Other Phone: |
| Gender:◻ Male◻ Female◻ Other | What is your child’s race? (select all that apply) | Ethnicity:◻ Not Hispanic or Latino◻ Hispanic or Latino |
| ◻ White◻ Black/African American◻ Native American | ◻ Asian or Pacific Islander◻ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child’s Physician:  | Child’s Dentist: | Medicaid/Hawki/Insurance ID Number: |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| YES, I give permission for my child to receive the following Child & Adolescent Health Services by a Registered Nurse, Registered Dental Hygienist, Social Worker, or other qualified staff (edit as needed for your program):  |

|  |  |
| --- | --- |
| * Education/Anticipatory Guidance
* Assistance Getting a Doctor or Dentist
 | * Referral and Other Care Coordination Services
* Capillary or Venous Blood Draws
 |
| * Assistance Getting Insurance
 | * Lead Poisoning Risk Assessment and Education
 |
| * Assistance Linking to Community Resources
 | * Emotional/Behavioral Assessment
 |
| * Assistance Getting Transportation
 | * Immunizations
 |
| * Assistance Getting Interpreter Services
 | * Developmental Tests
 |
| * Other services added here
 | * Dental Screening and Fluoride Application
 |

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| 🞎 | **NO**, I do not give permission for my child to receive services. |
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| **Please answer the following questions:** |
| 1. How do you pay for your child’s dental care? (please check one) |
| 🞎 Self Pay | 🞎 Medicaid/Dental Wellness Plan Kids | 🞎 Hawki | 🞎 Private insurance | 🞎 Other |
| 2. My child’s most recent dental visit was within the past: (please check one) |
|  🞎 6 months | 🞎 1 year | 🞎 3 years | 🞎 5 years | 🞎 has never seen a dentist 🞎 Unknown |
| 3. List any concerns you have about your child’s mouth or teeth:  |  |
|

|  |  |
| --- | --- |
| 4. Does your child have a source of medical care? | 🞎 Yes 🞎 No 🞎 Unknown  |
| 5. Does your child have medical insurance?  | 🞎 Yes 🞎 No 🞎 Unknown  |
| 6. My child’s most recent medical visit for a well-child/adolescent exam was within the past:  |
|  🞎 3 months | 🞎 6 months | 🞎 12 months | 🞎 more than 1 year | 🞎 Unknown |

 |
| 7. Are your child’s immunizations up to date? | 🞎 Yes | 🞎 No | Explain:  |  |
| 8. Is your child currently taking any medications? | 🞎 Yes | 🞎 No | Explain:  |  |
| 9. Does your child have any allergies? | 🞎 Yes | 🞎 No | Explain:  |  |
| List additional medications here:  |  |
| List additional allergies here: |  |

I consent to insert agency name use of email and texting to send me scheduling, care coordination, and child health services information. |
|   | 🞎 Yes | 🞎 No | Parent/Guardian Email address: |  | Parent/Guardian Cell phone: |  |  |

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| --- |
| * I was offered a Notice of Privacy Practices.
* I understand that this consent for services is valid for one (1) year unless withdrawn in writing by parent, guardian or client (if of legal age).
* I understand that the oral health services that will be received do not take the place of regular dental checkups at a dental office.
* I understand that these services are provided under the Iowa Department of Health and Human Services, Maternal and Child & Adolescent Health Program.
* I understand records created and maintained as part of this program are the property of the Iowa Department of Health and Human Services.
* I understand that the information from these records may be shared with the Iowa Department of Health and Human Services and its agents; Title V contractors and their subcontractors; Iowa Medicaid Enterprise or designee for care coordination, audit and quality improvement, or other legally authorized purposes.
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| **Printed Name of Parent/Guardian, or Client (if of legal age)** |  | **Date** |

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| --- | --- | --- |
| **Signature of Parent/Guardian, or Client (if of legal age)** |  | **Date** |

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