Your User Name 7/17/12 9:37 AM
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MATURA Action I-Smile™ Program
Head Start Consent Form and Release of Information

Child's Name:		Age	Date of Birth
Street address/city:	Phone:		
Doctor:	Dentist:		
Medicaid ID number:	Race of child:	____ Girl ____ Boy	

_____ Yes, I give permission for my child to a dental screening and a fluoride varnish application.

_____ No, I do not give permission for my child to receive dental services.

Please answer the following medical questions.

1. Does your child have a regular medical doctor? ____Yes ____ No
   When was your child's last doctor visit? _____
2. Are your child's immunizations (shots) up to date? ____ Yes ____ No
3. Does your child have medical insurance? ____ Yes ____ No
4. Is your child taking any medications right now? ____ Yes ____ No
5. Is your child allergic to anything? ____ Yes ____ No
   If you answered Yes to #4 or #5 please list: _____

_____

Please answer the following dental questions.

1. Does your child have a regular dentist? ____ Yes ____ No
   If yes, how often does your child see that dentist? Every 6 months OR Yearly
2. Your child's most recent dental visit was within the past: (check one)
   _____ 6 months ____ 1 year ____ 3 years ____ 5years ____Has never seen a dentist
3. How do you pay for your child's dental care? (check one)
   ____ Self-Pay ____ Medicaid/Title19 ____ ***hawk-i*** ____ Private dental insurance ____ Other

- I understand that these services are provided under the Iowa Department of Public Health, Maternal and Child Health Program.
- I understand records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health, Bureaus of Family Health or Oral and Health Delivery Systems, or designee.
- I understand this consent is good for 1(one) year unless withdrawn in writing by the parent or guardian.
- **This Dental service does not replace your child's regular Dental visits.**

_____

Parent or Guardian Signature Printed Name Date

I voluntarily authorize _____MATURA Action_____ to release, obtain, or exchange information with the following: _____physicians, dentists, schools and Head Start staff_____.
This release does *not* authorize disclosure of material protected by federal and/or state law applicable to substance abuse, mental health, and/or AIDS-related information.

_____

Parent/Guardian Signature **Date**