DuPage County Health Department SEALANT Agreement and Release of Liability *PLEASE PRINT CLEARLY IN PEN*

CHILD'S FIRST NAME______________________________ **LAST NAME**_________________________________ **CHILD'S AGE** _________

CHILD'S RACE___________________________ **DATE OF BIRTH**____/____/________ **SEX** Male Female

Parent/Guardian's Name____ **Telephone Number**_________ ____________

Address____ **CITY**__________________ **ZIP CODE**____________________

School _________________ **Grade** ________ **Teachers Name** ____________________________

HEALTH HISTORY

Circle if your child has had any of the following:

Heart Murmur, Tuberculosis, HIV/AID, Infectious Hepatitis, High Blood Pressure, Rheumatic Fever
Asthma, Allergies, Latex Allergy, Diabetes, Heart Problems, Liver & Kidney Problems

My Child is in good health. YES NO
Is your child allergic to anything? YES NO **List Allergies:** ____________________________________
Is your child taking any medications? YES NO **List Medications:** ________________________________
Is your child under care of a doctor now? YES NO **Why?** ____
My child is eligible for the **Free or Reduced Lunch Program** YES NO
Is your child on **Medicaid?** YES NO **If yes, please include your child's Medicaid RECIPIENT ID#** ___ ___ ___ ___ ___ ___ ___ ___ ___
Is your child covered by other dental insurance? YES NO **Name of Insurance:** _______________________ *(9 digit # on back of Medicaid card)*
Date of Last Dental Exam?_____/_____/________ *Your Medicaid will be billed*
Name of Family Dentist ____________________
How many people live in your household? _________________

PLEASE CIRCLE YOUR ANNUAL FAMILY INCOME:

21,775 or less	52,559 or less	83,343 or less
29,471 or less	60,255 or less	91,039 or less
37,167 or less	67,951 or less	98,735 or less
44,863 or less	75,647 or less	106,431 or more

Release of Liability for the Sealant Programs I, the undersigned parent or guardian have read the written fact sheets or brochures regarding dental sealants. I, the undersigned also realize that dental sealants are not a permanent restoration and require periodic examination by a licensed dentist and replacement if lost or damaged. Dental sealants will not prevent decay, they are a deterrent to decay if maintained properly. The success of this procedure is dependent upon the cooperation of the child during the application, oral hygiene habits, regular dental visits, diet, susceptibility to dental caries and other circumstances that affect the oral cavity. I hereby release, waive and discharge the DuPage County Health Department and the Illinois Department of Public Health, their employees and agents, from any liability to me, my personal representatives or next of kin for any and all damaged any claim or demands made on account of injury or dental disease resulting from the application of dental sealants. I have read and understood this agreement and voluntarily agree to all of its terms and conditions. I understand that the DuPage County Health Department is providing these procedures as a public service and has my permission to recheck and replace sealants as dictated by the grant. This authorization expires five years from this date.

If eligible, services may include an exam, cleaning, fluoride and sealants. Licensed dentists and dental hygienists will come to your child's school with portable equipment to perform these services. In order for your child to fully participate, you MUST complete the form and SIGN below. Any child who returns a form will be eligible to receive an exam. Do not return this form if you are not interested in the services.

Signature of Parent/Guardian ____ **DATE**____/____/______ 7/15