DENTAL TREATMENT CONSENT

Name of Student _____

School Year ---_____ D.O.B. _____ Gender _____M_____F

Please √ box next to the consent of your choice then sign below.

☐ As parent/guardian of the above named student, I give my consent to the routine performance of dental examinations, prophylaxes and treatments necessary to treat any dental/oral deficiency, abnormality and/or infection. This may include the use of behavior management techniques, local anesthesia and/or analgesia, and medications. In the event that treatment is beyond the scope of this facility, a letter of explanation and further recommendations will be sent to me from the HMS consulting dentist.

☐ As parent/guardian of the above named student, I decline the offer of dental examinations and treatments at HMS. I understand that my child is to be examined twice annually as recommended by the PA Department of Health for school-aged children and that the HMS Department of Nursing Services will receive a mailed or faxed (215-662-5159) report from the dentist. My child is seen for care by:

_____

_____

If documentation from your dentist is not received during the school year, a dental screening by the HMS consulting dentist will be carried out in accordance to state education regulations.

Signature of parent/guardian _____

Date _____

DR 7/13