WELL-AHEAD

MOVING LOUISIANA'S HEALTH FORWARD

Student's Name: Last First Middle Initial		
	Zip Code:	
Student's Date of Birth:	Age:	Sex: ❑ M ❑ F
Race: ❑American Indian or Alaska Native ❑Asian ❑Black or African American ❑White ❑Native Hawaiian or Other Pacific Islander ❑More than one race		
School:		Student's Grade: ❑1st ❑2nd ❑3rd
Name of Student's Primary Care Physician: Please check if student does not have a Primary Care Provider ❑		Phone: ( )
Name of Student's Dentist: Please check if student does not have a Dentist ❑		Phone: ( )
Does your child have any known allergies to latex? ❑ Yes ❑No		

How long has it been since your child last visited the dentist? Include all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as a dental hygienists.

❑ 6 months or less
❑ More than 6 months, but more than 1 year ago
❑More than 1 year ago, but not more than 3 years ago.
❑More than 3 years ago
❑ Never has been to the dentist
❑ Don't know/don't remember

What was the main reason that your child last visited the dentist?

❑ Went in on my own for check-up, examination or cleaning
❑ Was called in by the dentist for check-up, examination or cleaning
❑ Something was wrong, bothering me or hurting
❑ Went for treatment of a condition that dentist discovered at earlier check-up or examination.
❑Other
❑Don't know/don't remember

Confidentiality: Well-Ahead Louisiana adheres to all current laws regarding confidentiality of health services in general and specifically as they relate to services to minors. All medical and mental health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA).

BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW THE STATE HEALTH DEPARTMENT TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD BY A LICENSED DENTIST OR HYGIENIST:

♦screening by a local dentist♦dental sealants♦fluoride varnish♦referral to school nurse♦referral to local dentist or safety net clinic♦

I, as parent/guardian, understand the information on this form. I give permission for dental providers or Louisiana Seals Smiles program to perform a basic dental screening of my child's teeth. I also give permission for these same individuals to put dental sealants & fluoride varnish on my child's teeth if they are needed. I also understand that my child's personal information will be kept confidential and will not be shared with any person who is not directly involved in the care of my child.

_____ _____

Printed Name of Parent/Legal Guardian/Student **Relationship**

_____ _____

Signature of Parent/Legal Guardian **Date**

This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.