(Legal) Teacher ______________________________

NAME ____________________________________ School ______________________ Grade ______

Tooth B.U.D.D.S. HEALTH HISTORY/CONSENT

***B**ringing **U**nderstanding of **D**ental **D**isease to **S**chools*

Date of Birth: ____________________ Gender: ☐ M ☐ F Race: White Hispanic Native American African American Other

Parent/Guardian's Name: ____

Home Address: ____ City: ________________ Zip: __________

Parent Phone/Cell: ____________________________ Text: Y N Email: ____________________________

Does your child have or qualify AHCCCS? YES NO If yes, plan name and ID # ____________________________

Does your child have PRIVATE dental insurance? (statistical purposes only) YES NO

Please note that AHCCCS insurances will be billed for services provided by the team when applicable.

DENTAL HISTORY/INFORMATION

1. About how long has it been since your child's last dental appointment? **(Please circle one)**

Within the last year *More than a year ago* *Has never seen a dentist*

2. Is your child experiencing any mouth pain (toothache, sore gums, etc.)? YES NO

3. Does your child have an established dentist? YES NO If yes, name of dentist ______________________

I give consent for my child to receive the following FREE dental services provided by a licensed dental hygienist: ***(please initial)***

______ **ALL** preventive services offered including a dental screening, cleaning, sealants, fluoride varnish and Silver Diamine Fluoride.

***OR* CHOOSE SERVICES....**

Screening ☐ Sealants ☐ Cleaning ☐ Fluoride Varnish ☐ Silver Diamine Fluoride ☐

- -

______ **NO SERVICES** at this time.

HEALTH HISTORY

Does your child have or has your child had (please circle):

				Allergic to…	
Asthma	Yes No	Congenital Heart Disease	Yes No	Latex	Yes No
Heart Murmur	Yes No	Rheumatic Heart Disease	Yes No	Medicine	Yes No
Diabetes	Yes No	Bleeding Problems	Yes No	Nuts	Yes No
Seizures	Yes No	Artificial limbs or joints	Yes No	Milk	Yes No
Tuberculosis	Yes No			Other ______________	

1. Is your child taking any medications**?** YES NO

   If yes, what medications? ____

2. Is there anything else we should know about the health of your child?

____

____

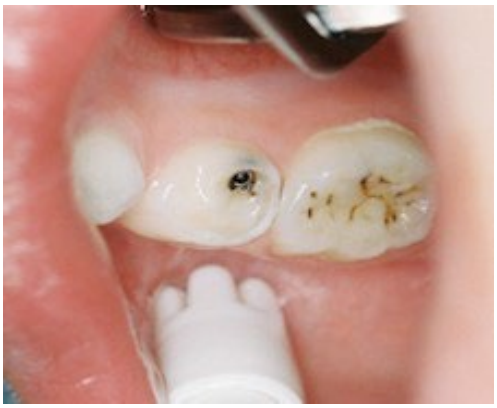
TURN OVER

Tooth B.U.D.D.S follows the CDC guidelines to minimize the risk of COVID transmission and is compliant with all school mandates.

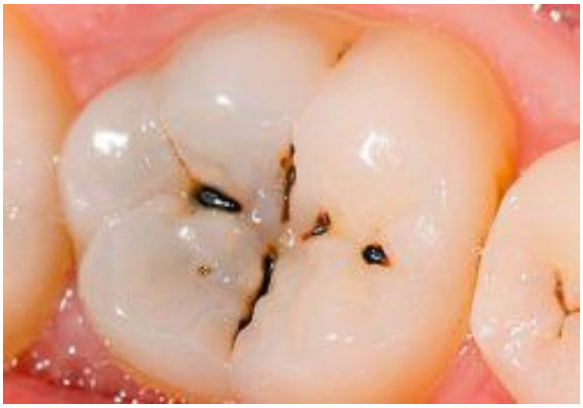
SILVER DIAMINE FLUORIDE (SDF) *STOPS ACTIVE DECAY (CAVITY) ONCE IT HAS STARTED*

Silver Diamine Fluoride (SDF) is an antimicrobial liquid that is brushed directly onto a cavity, killing the decay causing bacteria and stopping the cavity from getting worse. It is being used as a safe and effective alternative approach to control cavities in children. NO DRILLS, NO NEEDLES, NO SEDATION. Although SDF is well documented for controlling cavities, we still highly recommend you see your dentist for a full examine with x- rays.

Benefits: Arrests (stops) the decay process which causes a cavity.



Active Decay ARRESTED by Silver Diamine Fluoride



Arrests even small cavities from getting bigger

Possible Side Effects:

- A cavity with Silver Diamine Fluoride on it will turn a permanent dark brown or black color. This is an indication the decay in the tooth is arresting. Healthy tooth surfaces are unaffected and will stay bright white. ONLY areas that are being destroyed by bacteria turn black.
- If Silver Diamine Fluoride comes in contact with skin and/gums, *temporary* discoloration will occur.

Your signature on this form certifies a.) you have read and fully understand the information provided on the form, b.) all of your questions have been answered, c.) you have received a copy if requested, d.) you understand the treatment, risks and benefits and that you may refuse treatment e.) and that you accept dental treatment for your child under the described terms and conditions. ***** *WE WILL NOT PLACE SDF ON FRONT TEETH WHERE IT WILL SHOW.*

EMERGENCY CONTACT (if parent/guardian unavailable)

Name_____Phone: (_____)_____

_____ I give permission for my child's photo to be used for promotional materials.

I am the parent or guardian of the child named above. To the best of my knowledge, the medical history questions have been answered correctly and accurately. I understand that the Affiliated Practice Dental Hygienist providing care is an Arizona licensed dental hygienist and that this care does not take the place of a complete dental examination or dental care. I understand that the hygienist will refer my child to a dentist for treatment outside the hygienist's scope of practice, and that if my child has not received the treatment, the dental hygienist may not provide further treatment.

Name of Parent/Guardian (Printed) _____

Signature_____Date _____