

**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

How many people live in your household. \_\_\_\_\_

**PLEASE CIRCLE YOUR ANNUAL FAMILY INCOME**

20,796 or less	49,596 or less	78,396 or less
26,796 or less	56,796 or less	85,596 or less
35,196 or less	63,996 or less	92,796 or less
42,396 or less	71,196 or less	99,996 or more

My child is eligible for the **Free or Reduced Lunch Program** YES NO

Is your child on **Public Aid/Medical Card?** YES NO

Is your child on **All Kids?** YES NO

If your child has Public Aid/Medical Card or All Kids you

**MUST include your child's RECIPIENT ID#** \_\_\_\_\_

*Your Medial/All Kids* (9 digit # on back of medi-plan card or on All Kids card)

*Will Be Billed*

Is your child covered by other dental insurance YES NO

**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 damage, d 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 authorizaton 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.**

<b>HEALTH HISTORY</b>	
<b>Circle If Your Child Has Had Any Of The Following?</b>	
Heart Murmur	
Diabetes	
Rheumatic Fever	
Epilepsy	
Blood Diseases or Disorders	
Asthma	
Latex Allergy	
Allergies	
List Allergies: _____	
_____	
<b>Is your child taking any medications</b> YES NO	
List Medications: _____	
_____	
Date of Last Dental Exam? _____	
Name of Family Dentist _____	

**SIGNATURE OF PARENT or GUARDIAN** \_\_\_\_\_

DATE \_\_\_\_\_ 8/08