In-School Dental Screening Consent Form

Student Information

Student Name

Date of Birth

School Name

Grade

Teacher

Parent/Guardian Information

Parent/Guardian Name

Phone Number

Email Address

Home Address

Medical Information

Allergies or Medical Conditions

Consent

☐ I give permission for my child to receive a dental screening at school.

☐ I do not give permission for my child to receive a dental screening at school.

Parent/Guardian Signature Date