In-School Dental Screening Consent Form

Student Information

Student Name				
Date of Birth				
Date of Birth				
School Name				
Grade				
Teacher				
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Parent/Guardian In	tormation			
Parent/Guardian Name				
Phone Number				
Phone Number				
Email Address				
Home Address				
Medical Informatio	n			
Wedicai iiiioiiialio	11			
Allergies or Medical Conditions	;			
Consent				
I give permission for my child to	receive a dental screening	at scho	ool.	
I do not give permission for my	child to receive a dental scre	enina	at school	
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Parent/Guardian Signature		Date		
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