Dear Parent or Guardian:

The Howard University College of Dentistry is offering dental services for your child during our annual Give Kids a Smile Day on Friday, February 8, 2020. **These services will be at no cost to your family** and will be provided at the Howard University College of Dentistry (600 W Street, NW, Washington, DC 20059). With the supervision of licensed dentists, the dental residents, dental and hygiene students of Howard University College of Dentistry will provide dental screenings, radiographs (as needed), cleanings, fluoride treatments, sealants, fillings and extractions (as needed). Sealants are thin plastic coatings that are placed on the tops of your child's back teeth to help prevent cavities. Fluoride treatments help strengthen the teeth against decay. Every effort will be taken to offer comfort to your child. Treatment that includes fillings or tooth extractions will require numbing the area with dental anesthesia. Each child will be sent home with a dental report form. Prior to the event, we will be completing dental screenings at your child's school to help us to better prepare for your child's dental needs. These screenings will include only the use of a dental mirror and dental explorer to check each tooth.

By signing this form, I consent for my child's participation in the Give Kids a Smile Day program, which may include the dental treatments stated above and will include the pre dental screenings. I certify that I have read and fully understand the consent to treatment and may refuse to sign this authorization.

First Name____________________________MI________Last Name ________________________________
Date of Birth_________________Sex_________
Address ____
Street City State Zip Code
Phone Number ____________________________
In case of an emergency, contact name_______________________________Phone___________________
Does your child have or has your child had :

Asthma	**Y**	**N**	**Congenital Heart Disease**	**Y**	**N**
Heart Murmur	**Y**	**N**	**Rheumatic Heart Disease**	**Y**	**N**
Diabetes	**Y**	**N**	**Bleeding Problems**	**Y**	**N**

Is your child taking any medications/ using an inhaler? Y N
If Yes, what medications/ how often? ____
Does your child have any allergies? Y N If yes, what allergies? _______________________
Has your child had any other serious illnesses or operations? Y N
If Yes, what illness or operation? ____
Does your child have a dentist? Y N If yes, what is his/her name? __________________________
Is there anything else we should know about the health of your child? ____________________________

Signature of Parent or Guardian Relationship to Child Date