Rocklin Unified School District

Health Services

www.RocklinUSD.org/Health

Oral Health Screening

Student Name: _____ Date of Birth: _____ Teacher: _____

Parent/Guardian Name: _____ Relationship to Student: _____

California law (*Education Code* Section 49452.8) states all students must have a dental screening. Dental screenings only find obvious dental problems and serve to identify students who need further examination and dental treatment.

- ☐ The above named student sees a dentist regularly.
- ☐ The above named student does not have a dentist.
- ☐ We would like assistance finding a dentist, or scheduling an appointment.
- ☐ We would like assistance verifying our insurance coverage or options.
- ☐ We may need financial assistance for any procedures not covered by insurance.
- ☐ Other: _____

Consent for Screening at School

On the date of **May 9th** a licensed dental professional will be coming to your student's class. If you consent for your student to have a dental screening, this will fulfill the legal requirement. The results will be kept on file at school and sent home.

☐ I consent for the student named above to receive a basic dental screening. I will not hold the dental professional responsible for the oral health consequences or results should I choose NOT to follow the recommendations sent home after the screening. I understand:

1. No x-rays will be taken.
2. The screening does not take the place of a thorough dental examination and that I will need to secure the services of a dentist in order for my student to receive a complete dental examination necessary to establish and maintain oral health.
3. Receiving this dental screening does not establish any new, ongoing or continuing dental professional-patient relationship. I am free to establish such a dental professional-patient relationship for my student in the future with the dental professional performing this screening or another of my choice.

☐ I do not want my student to be screened at this time.

_____	_____	_____
Parent/Guardian Printed Name	Parent/Guardian Signature	Date

I give my permission for the screening dental professional to contact me and discuss dental concerns if needed.

I prefer to be contacted by:

☐ Phone: (_____) _____-_____ ☐ Email address: _____

☐ Mailing address: _____

_____	_____	_____
Parent/Guardian Printed Name	Parent/Guardian Signature	Date