Internal use only:
Reviewed by: ________
Date: _______________

Give Kids A Smile® Day

Pima Community College Site

Date of Event: 03/05/2022

Give Kids A Smile® Child Information, Health History and Consent Form
To be completed by a parent or legal guardian:

Child's Full Name: (first, MI, last):

Child's Date of Birth (mm/dd/yyyy): __ __ / __ __ / __ __ __ __

Child's Gender: ☐ Male ☐ Female ☐ Intersex

Child's Ethnicity: ☐ African American ☐ Hispanic ☐ Caucasian (white) ☐ Native American ☐ Other: ☐ I prefer not to answer

Child's Home Address (Street/City/State/Zip)

Phone Number: (may receive communication regarding your child's care)

Email:

Name of Parent/Guardian (First Last):

Date of Child's Last Dental Visit: ☐ A previous Give Kids A Smile event ☐ Within the past year ☐ 1-3 years ago ☐ More than 3 years ago ☐ Don't know ☐ Never

Does your child have a dentist? ☐ Yes ☐ No *If yes, please specify:*

Does your child have dental insurance, AHCCCS or Kidscare? ☐ Yes ☐ No ☐ Don't Know

If yes, please provide AHCCCS ID # A __ __ __ __ __ __ __ __

Type of AHCCCS Plan (if eligible): ☐ United Healthcare ☐ Banner University Family Care/CMDP ☐ AZ Complete Health ☐AIHP ☐ Unknown ☐Does Not Apply ☐None ☐ My child has private dental insurance

What is your annual household income? ☐ Under $10,000 ☐ $10,001-$20,000 ☐ $20,001-$30,000 ☐ $30,001-$40,000 ☐ $40,001-$50,000 ☐ $50,000 and above ☐ Decline to Answer

How many people, including all adults and children, live in your home?
☐ 2-3 ☐4-5 ☐6-7 ☐8-9 ☐10 or more ☐Decline to answer

Have you ever applied for AHCCCS or Kidscare? ☐ Yes ☐ No ☐ Unsure

Who should be contacted on the day of service (02/15/2020) in the event of an emergency?
Emergency Contact Name: Relationship: Contact Phone:

Name of child's doctor/pediatrician:

Has your child ever had a surgery, operation or been hospitalized? ☐ Yes ☐ No
If yes, describe:

Is your child taking any medications, pills, drugs (including over-the-counter medicine/vitamins): ☐ Yes ☐ No
If yes, please list:

Does your child have any allergies? ☐ Yes ☐ No *If yes, please specify:*

Does your child have any of the conditions listed below (now or in past)?

☐ Asthma/Breathing Problems	☐ HIV/AIDS or Hepatitis B	☐ Kidney or Liver Problems	☐ ADD or ADHD
☐ Diabetes Type I	☐ Congenital Heart Disease	☐ Bleeding Problems	☐ Autism
☐ Diabetes Type II	☐ Heart Murmur	☐ Latex or Nickel Allergies	☐ Down Syndrome
☐ Seizures	☐ Rheumatic Heart Disease	☐ Sensitivity to Wood/Resin Products	☐ Emotional Problems
			☐ Hives/rashes

Is there anything else we should know about the health of your child? ☐ Yes ☐ No
If yes, please specify:

Has your child been a victim of any abuse? ☐ Yes ☐ No

Is your child up to date on immunizations? ☐ Yes ☐ No

To the best of my knowledge, the medical history questions have been answered correctly and accurately. **Initials**: **X**____________

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Give Kids A Smile® PATIENT WAIVER, PHOTO RELEASE, AND CONSENT FOR DENTAL TREATMENT

CHILD'S NAME (PLEASE PRINT): ____

I am the above child's parent or guardian and am at least 18 years old. I give consent for my child to participate in the dental screening as well as the preventive and restorative dentistry program conducted by members of the Arizona Dental Foundation and affiliates being offered at Pima Community College Dental Clinic at Pima CC West Campus, 2202 W. Anklam Road, Tucson, Arizona on (03/05/2022). To the best of my knowledge, the medical history questions have been answered correctly and accurately.

I allow my child to receive x-rays, sealants, fluoride, silver diamine fluoride (SDF), and local anesthetic (numbing of the teeth), pulpotomies (baby root canal) or root canal therapy, and extraction of teeth. I allow my child to receive oxygen and/or nitrous oxide if necessary.

Give Kids A Smile Day is a one day event. While the volunteer hygienists, dentists and dental specialists offer high quality procedures with good equipment, I understand that, because of the number of children needing to be seen, all treatment may not be completed and my child might not receive multiple extractions or multiple fillings. I also understand that the dental care providers are volunteers and are not available for follow-up care in the event of complications. I agree to seek any follow-up care my child might need from my local dentist, dental clinic, or hospital emergency room.

In consideration of the free dental care services received in conjunction with Give Kids A Smile, I for myself and for my child, do hereby waive and release Arizona Dental Foundation or any persons or organizations acting on their behalf or sponsoring or volunteering at this event from all claims of liability arising out of my acceptance of such free care including but not limited to medical, surgical, dental, or other health care or medical advice. I also understand that some of the dental care may be provided by a dental student under the direction of a faculty dentist or hygienist.

I grant the ADA FOUNDATION, the AMERICAN DENTAL ASSOCIATION, Arizona Dental Foundation and its agents the right to use my child's pictures, voice, and other reproductions in connection with advertising or publicizing, ADA, Foundation, Arizona Dental Foundation, and its activities in all forms of media from this point forward. I authorize the use of the images without compensation to me. All negatives, prints, digital reproductions shall be property of the organization taking the image.

I understand that I will receive a copy of the treatment completed. The original patient record will be maintained by the Arizona Dental Foundation, 3193 N Drinkwater, Scottsdale, Arizona 85251.

I have read or had read to me this document; that all the blanks were filled in before I signed; that I understand the nature of this consent; and that this consent is provided voluntarily. I intend to be legally bound by my signature.

Signature of Parent/Guardian: ____ Date: ______________

ACKNOWLEDGEMENT OF RECEIPT OF GIVE KIDS A SMILE NOTICE OF PRIVACY PRACTICES

I have received a copy of the Give Kids a Smile Notice of Privacy Practices either online during pre-registration (reviewed on website) or in person at the Give Kids a Smile event.

Signature of Parent/Guardian: ____ Date: ______________

Because ADF recognizes "no child left behind", we will accept children of all nationalities and ethnicities. The demographic information collected is for research purposes only. However, this program is designed for children ages 6-12 who are experiencing oral pain, do not qualify for AHCCCS and cannot afford dental insurance.