**Parental Consent Form for Dental Services**

Dear Parent/Guardian,

Your child’s school is offering oral health services during an upcoming field trip. The dental clinic, hosted by the California Dental Association Foundation on October 9-12 in Weaverville, California, will include an oral health assessment, dental examination, x-rays, sealants, fluoride varnish application, and oral health education provided by licensed dental professionals.

Parents may attend the field trip to provide consent to additional treatment such as fillings and extractions, if needed. Parents wishing to transport their child in their personal vehicle may opt-in to receive a gas gift card with the timely return of this consent form due 9/16/2024. If you require a gas gift card, please indicate in the field box on page 3.

Alternatively, parents can sign up for an appointment for free dental care for their child on Saturday, October 12 at the Weaverville Veterans Hall between 9am-3pm (appointments are limited) by emailing [Myishia.Johnson@cda.org](mailto:Myishia.Johnson@cda.org). There will be limited spots for parent dental care as well.

Please carefully read the following information and complete the consent form below.

**Services Provided:**

1. **Oral Health Assessment:** A general assessment of your child’s oral health to identify any potential issues.
2. **Dental Examination:** A thorough examination of your child’s teeth, gums, and mouth by a licensed dentist.
3. **X-Rays:** Dental x-rays to detect cavities, bone loss, and other dental issues that are not visible during the examination.
4. **Sealants:** Application of a protective coating on the chewing surfaces of your child’s molars to prevent cavities.
5. **Fluoride Varnish:** A fluoride treatment to help strengthen your child’s teeth and prevent decay.
6. **Oral Health Education:** Instruction on proper brushing, flossing, and overall oral hygiene practices.

Consent Statement:

I, the undersigned, hereby give permission for my child,   
  
**[Child’s name and age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]**, to participate in the oral health program provided by the California Dental Association Foundation. I understand that the services provided will include an oral health assessment, dental examination, x-rays, sealants, fluoride varnish, and oral health education. I acknowledge that these services will be performed by licensed dental professionals operating in a volunteer capacity.

I have been informed of the nature and purpose of the services and understand that participation is voluntary. I also understand that I may withdraw my consent at any time by notifying the school **within 24 hours of the event in writing**.

I acknowledge that the dental professionals will take necessary precautions to ensure my child’s safety. However, I understand that as with any health procedure, there may be risks involved.

I, for myself and anyone entitled to claim through me, hereby release, waive, and discharge  
  
**[School Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]**, its staff, California Dental Association Foundation, and the dental professionals from any and all liability arising from my acceptance of these services.

**Parent/Guardian Information:**

**Parent/Guardian Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Child:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent and Signature:**

* **I consent to all services described above:**
  + ☐ Yes
  + ☐ No
* **I only consent to specific services marked below:**
  + ☐ Oral Health Assessment
  + ☐ Dental Examination
  + ☐ X-Rays
  + ☐ Sealants
  + ☐ Fluoride Varnish
  + ☐ Oral Health Education
* I plan to attend the field trip with my child in order for them to receive additional treatment if needed.
  + ☐ Yes
  + ☐ No
* I plan to make my own appointment for my child outside of the school field trip to receive dental treatment for my child. (email: [Myishia.Johnson@cda.org](mailto:Myishia.Johnson@cda.org) by September 30 for appointment)
  + ☐ Yes
  + ☐ No
* I am providing transportation for my child from outside of Weaverville and would like to receive a $30 gas gift card.
  + ☐ Yes
  + ☐ No

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return this form to the school by **September 16, 2024**.

**Clinic Details**

Location: Weaverville Veterans Hall  
109 Memorial Dr, Weaverville, CA 96093  
Date: Wednesday October 8 – Saturday October 12

Time: Appointments start at 9am, last appointment at 3pm

Spanish translators will be available