KELLOGG
COMMUNITY COLLEGE
450 North Avenue, Battle Creek, MI 49017-3397 PHONE 269 965 3931 WEB www.kellogg.edu

Parent/Legal Guardian Consent Form to authorize free basic dental hygiene services at Kellogg Community College, Department of Dental Hygiene Education, 450 North Ave, Battle Creek.

I am the legal guardian/parent of _____ date of birth: _____

☐ YES, I agree to have my youth participate in free dental hygiene services at Kellogg Community College. ***If yes, complete remainder of form and sign and date at the bottom.***

☐ NO, I do NOT wish for my youth to participate. ***If no, please sign and date at the bottom.***

I consent for my child to receive the following dental hygiene services. **Please place a check mark next to each desired service.**

☐ Teeth cleaning
☐ Fluoride treatment
☐ Bitewing, Full Mouth Series, and/or Panoramic radiographs as prescribed.
☐ Digital X-rays sent to Dr. _____ (name of child's dentist)
☐ Evaluation for and placement of sealants on first and second permanent molars if needed

- I understand that my child will also receive the following services:

☐ Oral cancer screening
☐ Cavity detection screening
☐ Oral hygiene instructions
☐ Referrals for continued care (and we will send the x-ray images to the child's dentist if you **provide her/his name**)

- I understand that KCC senior dental hygiene students will be performing all services, closely supervised by dental hygiene clinical instructors and the supervising dentist.
- I understand that no invasive or emergency procedures will be performed on my child.
- I do not hold Kellogg Community College accountable for the oral health condition of my child.
- I understand that all services are provided free of charge.

In order for your child to participate in this activity, we ***must*** have your signature below.

Thank you.

_____ _____
Parent / Legal Guardian Date

Applicant Name:

Medical History

1. Are you having any pain or discomfort at this time? ☐ Yes ☐ No

2. Have you been a patient in a hospital in the last two years? ☐ Yes ☐ No
   If yes, for which condition?

3. Are you being treated by a physician now? ☐ Yes ☐ No
   If yes, name and address of physician

4. Do you have any of the following diseases? ☐ Yes ☐ No
   If you answer yes to ANY of these items, please let us know IMMEDIATELY.
   - Active turberculosis
   - Persistent cough greater than 3 weeks duration
   - Cough that produces blood

5. Have you experienced any of the following? ☐ Yes ☐ No

☐ Chest Pain	☐ Headaches	☐ Swollen Ankles
☐ Fainting Spells	☐ Shortness of Breath	☐ Seizures
☐ Recent Weight Loss	☐ Night Sweats	☐ Excessive Thirst
☐ Frequent Urination	☐ Bleeding Problems	☐ Excessive Bruising
☐ Dry Mouth	☐ Sinus Problems	☐ Jaundice (Yellowing of skin)

6. Do you have or have had any of the following?

Artificial Heart Valves	☐ Yes	☐ No
History of Infective Endocarditis	☐ Yes	☐ No
Congenital (at birth) Heart Defects or Heart Surgery as a child	☐ Yes	☐ No
Cardiovascular Disease or Heart Trouble	☐ Yes	☐ No
Heart Attack, Angina, Heart Surgery, Irregular Heartbeat High	☐ Yes	☐ No
Blood Pressure	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Cardiac Pacemaker or Other Cardiac Device	☐ Yes	☐ No
Artificial Joint Replacement	☐ Yes	☐ No
Cancer, Tumor	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Radiation	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Do you have frequent blood sugar values over 300/mg/dL?	☐ Yes	☐ No
AIDS or HIV Positive	☐ Yes	☐ No
Blood Disorders, such as Anemia, Hemophilia or Blood Transfusions	☐ Yes	☐ No
Asthma, Active Tuberculosis, Emphysema, or Other Lung Disease Hives or Skin Rash Hepatitis or Other Liver Problems	☐ Yes	☐ No
Stomach Problems, Ulcers	☐ Yes	☐ No
Venereal Disease, Sexually Transmitted Diseases (STD)	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Kidney or Bladder Disease	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Immune System Disorder	☐ Yes	☐ No

Applicant Name:

7. Are you allergic to any drug or medication? _____ ☐ Yes ☐ No
   - Local anesthetic _____ ☐ Yes ☐ No
   - Penicillin or Other Antibiotics _____ ☐ Yes ☐ No
   - Codeine or Other Narcotics _____ ☐ Yes ☐ No
   - Aspirin _____ ☐ Yes ☐ No
   - Iodine _____ ☐ Yes ☐ No
   - Sulfa Drugs _____ ☐ Yes ☐ No
   - Other _____ ☐ Yes ☐ No

8. Are you allergic to Latex or natural rubber products? _____ ☐ Yes ☐ No

9. Please list all drugs you are taking, including over the counter medication, diet supplements and recreational drugs?

Dental History

10. Do you have any dental implants? _____ ☐ Yes ☐ No

11. Do you have any abnormal bleeding associated with previous extractions, Surgery, or trauma? _____ ☐ Yes ☐ No

12. Have you had surgery or X-tray treatment for a tumor, grown or other Condition of the head and neck? _____ ☐ Yes ☐ No

13. Have you ever had a bad or unusual reaction to local anesthetic? _____ ☐ Yes ☐ No

14. Are you anxious about receiving dental treatment? _____ ☐ Yes ☐ No

15. Do you, or have you had any other disease or medical problems that are Not listed on this form?
    If yes, please explain _____ ☐ Yes ☐ No

16. Do you use tobacco products? _____ ☐ Yes ☐ No

17. Do you use alcohol? _____ ☐ Yes ☐ No
    If yes, do you drink more than 2 drinks a day on a regular basis? _____ ☐ Yes ☐ No

18. Woman – Are you or could you be pregnant? _____ ☐ Yes ☐ No

19. Do you have or have you had any of the following?

☐ Sensitivity, hot, cold or pressure
☐ Bleeding gums
☐ Popping, cracking of the jaw
☐ Frequent or recurrent sores in your mouth
☐ Clenching or grinding teeth
☐ Difficulty opening mouth
Bad breath

Date of Last Dental Cleaning

Date of Last Dental X-rays

_____

(Print Name)

(Signature: Patient, Parent or Guardian)
(if under 18 years old, parent or guardian must sign)