DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service

Hopi Health Care Center
P.O. Box 4000
Highway 264, MM 388
Polacca, Arizona 86042

Permission to Participate in the Dental Disease Prevention Program

Please Print

School_____Date_____

Name of Student_____Date of Birth_____

Grade_____Class_____Teacher_____

By signing this form I give my permission for my child to participate in the Hopi Health Care Health Disease Prevention Dental Service Program. These services are to be provided by HHCC Dentists and/or Hygienists who are licensed and certified to provide the following Dental Services:

MARK ALL THAT APPLY

____Dental Screening _____ Fluoride Varnish

The following Dental Services will be delivered provided the HHCC Mobile Dental Van is operational for Dental Treatment.

Mark All That Apply.

_____Dental Examination _____X rays
____ Sealants _____Temporary Fillings
_____Cleanings _____ Fluoride Varnish

____Yes, Permission is Given _____No, Permission Is Not Given

Please provide the following brief medical history for you child:
MY CHILD:
-Is currently taking the following medication_____
-Has the following medical condition_____
-Has allergies to the following medication(s) or food(s)_____
-Is currently having their dental care provided by:_____

Parent/Guardian Signature_____Print Signature_____
Date:_____Address_____
Phone Number/Name 1_____
Phone Number /Name 2_____

A follow up letter will be given to your child regarding the status of their Dental Health.

If you have any questions or concerns regarding your child's oral health, please feel free to contact the Dental Department. To schedule a dental appointment please call:
928-737-6162 or 928-737-6163