

Sign Up Your Student

Please print clearly in blue or black ink. Fields marked * are required.

Return the completed form to your child's teacher.

1. STUDENT INFORMATION

Student First Name *

Student Last Name *

Date of Birth *

		/			/				
MM			DD			YYYY			

Grade * (check one)

☐ Pre-K ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

☐ Other: _____

School Name *

Teacher Name

2. PARENT / GUARDIAN INFORMATION

Parent / Guardian First Name *

Parent / Guardian Last Name *

Parent / Guardian Email *

Parent / Guardian Phone *

Street Address *

City *

State *

ZIP Code *

3. INSURANCE

Insurance Type * (check one)

☐ Medicaid ☐ PeachCare for Kids ☐ Private / Commercial ☐ No insurance

If you have private / commercial insurance, please complete the boxes below:

Policy Holder Name

Policy Holder Date of Birth MM / DD / YYYY

Subscriber ID

Insurance Company Phone Number

Student Name: _____ Date of Birth: ____ / ____ / _____

4. HEALTH HISTORY

Additional details of your child's health, including current medical treatment

Other significant past illnesses, alcohol and tobacco use (including smokeless)

Current medications, and any premedication needed for dental treatment

Medical History (check all that apply)

- | | | |
|---|---|---|
| ☐ AIDS/HIV Positive | ☐ Hemophilia/Bleeding Problems | ☐ Sickle Cell Anemia |
| ☐ Asthma | ☐ Kidney Disease | ☐ Tuberculosis |
| ☐ Cancer | ☐ Liver Disease | ☐ Wheelchair Access |
| ☐ Contagious Disease | ☐ Rheumatic/Scarlet Fever | ☐ Allergies to Medications |
| ☐ Diabetes | ☐ Seizures | |
| ☐ Heart Condition | ☐ Pregnant | ☐ None of the above |

Name and Phone # of Child's Physician

Note: If your child already has a dentist, you should keep going to that dentist.

5. IMPORTANT NOTICE & CONSENT *

- ☐ I understand that a licensed dental hygienist will be providing preventive dental services directly on-site at the school, operating under general supervision of a licensed dentist as permitted by Georgia law (O.C.G.A. § 43-11-74(h)). This includes procedures such as oral prophylaxis (cleanings), application of topical fluoride, and sealants, all performed with prior written parental/guardian consent for each student.

I've read the statement above and I agree. (check the box)

- ☐ I understand and consent to dental services being provided through teledentistry. I understand that teledentistry involves the use of electronic communications and is not the same as an in-person clinical examination performed in a dental office. The authorizing dentist will not be physically present during the teledentistry encounter. I understand that if an in-person examination or treatment is recommended or needed, I will be referred to an in-person dentist for further evaluation. I have been informed of the risks, benefits, and alternatives to teledentistry, including the option to receive care in person instead. I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I voluntarily consent to teledentistry services.

I've read the statement above and I agree. (check the box)

Signature of Parent / Guardian *

Date *

Printed Name of Parent / Guardian