Class: _____

Buddhist Tzu Chi Medical Foundation

Dental Screening Program (School)

School Name: Tzu Chi Academy Long Island Event Date: _____

School Address: 150 E. Main St. Oyster Bay, NY 11771

Name of Child: _____ Contact Number: _____

Date of Birth: _____ Gender ☐ Male ☐ Female Appointment Time: _____ AM / PM

I understand that by signing this form, I am consenting for my child to receive a basic oral health assessment or dental screening. I understand this screening is only a very basic evaluation and does not take the place of a thorough dental examination. I would need to secure the services of a dentist in order for my child to receive a complete dental examination necessary to establish and maintain oral health.

I also understand that receiving this dental screening does not establish any new, ongoing, or continuing doctor–patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the oral health consequences or results should I choose NOT to follow the recommendations listed below.

_____ _____ _____

Parent or Legal Guardian (Print Name) | Signature (of Patient or Legal Guardian) | Date

Dear Parent or Legal Guardian,

Dental screenings only find obvious dental problems and are meant to identify the need for dental care. No X-rays are taken, and this screening does not replace a thorough dental examination by a dentist.

Below are the results of the screening and my recommendation:

☐ Your child has no obvious dental problems but should receive routine examinations by a dentist.

☐ Your child appears to have some dental problems that should be evaluated by a dentist. Please make an appointment at your earliest convenience so that he/she can receive a complete examination. The dentist will determine what treatment is needed.

☐ Your child has some dental problems that appear to need immediate care. Contact a dentist as soon as possible for a complete examination.

☐ Dental Cleaning is recommended.

Additionally, I have explained the risks of NOT proceeding with the recommendation provided and fully responded to the questions posed to me by the parent or legal guardian.

_____

Name and Signature of Dental Professional | Date

Translation Provided By: (Name) _____ (Signature) _____ Patient's Initial: ___