

Release: I give permission for my physician's office to fax/send this completed form to

Holmes Elementary
Attn: Preschool
1350 W Truesdell St
Wilmington, OH 45177
Fax: (937) 382-2881

Child's name: _____ Date of Birth: _____
Parent's name: _____ Child's Age: _____
Address: _____ Date of Exam: _____

Signature of Parent or legal guardian: _____ Date: _____

Is your child currently receiving any of the following fluoride?

Topical Fluoridated Water Fluoride Supplement diet (tablets or liquid)

Does your child have any problems with teeth, gums, or mouth? yes or no

Has your child previously seen a dentist? yes or no

Name of Dentist seen: _____

Date seen: _____

Does your child have a chronic condition that requires him/her to be under physician supervision?

yes or no

Is your child currently receiving medication? yes or no

If yes, what type? _____

Child is reported to have (check all that apply):

Allergies Asthma Bleeding Diabetes
 Epilepsy Liver Disease Rheumatic Fever Sickle Cell
 Heart/Vascular Disease Other _____

Source of reimbursement:

EPSDT/Medicaid Federal, State, or Local Agency Head Start
 In-Kind Provider Parent/Guardian Other (Third Party Group) _____

