Pocono Mountain School District

Dental Screening Permission

Grades K, 2, 3, 4, 5, 7

Child's Name: _____ Grade: _____ Birthdate: _____

Written permission is required for your child to be given the periodic dental screening and other dental services required by state statute, during the years he/she is enrolled as a student in the district. You will be notified in advance of the dates and times of any screening or services and you have the right to be present if you so desire. There is no financial obligation on your part for these services.

In the event that you do not give your permission for these dental screening and services, the school will not provide these services and you will be required to have the services provided by a private dentist and reports provided to the district.

Please Check One:

_____ Yes (Permission Granted)
_____ No (Permission Denied) **Report from your private dentist will be required**

Does your child have dental insurance? _____ Yes or ____ No

If yes, name of insurance provider:_____

If MEDICAID/CHIP - Circle one - Medicaid, Gateway, United Healthcare, Keystone First, AmeriHealth Caritas, UPMC, Health Partners, Geisinger CHIP, Aetna, United Concordia Chip, Coventry Cares, Kidz Partners, Blue Cross CHIP, or Other_____

Does your child have a dentist? _____ Yes or _____ No

Name of dentist: _____
Phone #: _____

_____ _____
Parent/Guardian Signature Date