

**SHDS School House Dental Services**  
"We Style SMILES" Dr. Jerrold W. Smith, Sr., D.D.S.  
**CONSENT FOR DENTAL SERVICES**

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Student Name: \_\_\_\_\_ Student Number: \_\_\_\_\_

Birthdate: \_\_\_\_\_ School: \_\_\_\_\_

Telephone: \_\_\_\_\_ Room: \_\_\_\_\_

Dear Parent/Guardian:

Dental services including free dental examination, cleaning, and fluoride application will be provided to your child by licensed dentist. If your child needs treatment for dental problems you will be informed and referred to a dentist of your choice.

If you want your child to have this preventive dental care and you have a medical card, complete the information below.

Copy from your medical card exactly or send expired medical care to school.

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I give permission for \_\_\_\_\_ to have dental examination, cleaning and fluoride examination.

\_\_\_\_\_  
Signature Of Parent/Guardian

\_\_\_\_\_  
Date

If you have a medical card, please copy information from card to form below.

(The following information below will be found on the reverse side of your medical card)

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Birthdate

STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
MEDICAL ELIGIBILITY CARD

\_\_\_\_\_  
Case Number

(The following information below will be found on the front of your medical card.)

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State & Zip Code \_\_\_\_\_