Centre Volunteers
IN MEDICINE

Parent: Please return these forms to Centre Volunteers in Medicine by **April 17, 2020** in order for your child to receive an appointment.

We will call you with an appointment as soon as we complete the event schedule.

BE SURE TO ATTACH A COPY OF YOUR MOST RECENT FEDERAL TAX RETURN OR AT LEAST ONE PAYSTUB FOR EACH PERSON WITH A HOUSEHOLD INCOME WITH THIS APPLICATION

Send to:

Centre Volunteers in Medicine

Attention: Kristi Mattzela -- GKAS

2520 Green Tech Drive, Suite D

State College, PA 16803

CENTRE VOLUNTEERS IN MEDICINE

GIVE KIDS A SMILE AND VISION FOR THE FUTURE 2020
CONSENT FORM

Dear Parents/Guardians,

We welcome you in joining us for our *Give Kids A Smile* and *Vison for the Future* event to be **held April 24** Services will be provided to Centre County kids without dental and vision insurance. At the event **ALL** children will receive **ALL** the following services:

- ✓ Dental Exam
- ✓ X-rays
- ✓ Cleaning
- ✓ Sealants
- ✓ Brushing and Flossing Instructions
- ✓ Comprehensive orthodontic evaluation
- ✓ Fluoride Treatment
- ✓ Restoration of Decayed Areas
- ✓ Extraction of non-restorable teeth
- ✓ Vision exam (glasses if needed)
- ✓ Voucher for a free hearing screening

Please sign below to acknowledge that you give permission for your child to receive **ALL** of the free services listed above. This acknowledges that you received a copy of this consent form. **We will contact you with your appointment date and time closer to the day of the event.**

If you prefer your child NOT receive ALL services or if your child has urgent or immediate dental problems, attendance at this event is not for you. Please call Centre Volunteers in Medicine at (814) 231-4043 to learn about access to customized dental services.

*****IT IS YOUR RESPONSIBILITY AS A PARENT/GUARDIAN TO PROVIDE ANY PRE-MEDICATIONS YOUR CHILD MAY REQUIRE PRIOR TO DENTAL WORK. YOU WILL BE ASKED TO PROVIDE THE NAME, DATE AND TIME PRE-MEDICATION WAS ADMINISTERED WHEN YOU CHECK-IN THE DAY OF THE EVENT. (If you do not know if your child needs pre-medication or not, please ask your doctor/pediatrician.)**

Please return all forms AS SOON AS POSSIBLE and NO LATER than April 17 to:

Centre Volunteers in Medicine
Attention: Kristi Mattzela -- GKAS
2520 Green Tech Drive, Suite D
State College, PA 16803

Appointment Contact Information:

PARENT /GUARDIAN **PRINTED** NAME	PHONE #	EMAIL

Native Language:_____ **Do you need a translator?** ☐ Yes ☐ No

Parent/Guardian Signature: _____ Date: _____

Centre Volunteers in Medicine
2520 Green Tech Drive, Suite D
State College, PA 16803
Phone: 814 231-4043
FAX: 814 231-5274

Dental Registration Form

Patient Information

Name: _____ **Nickname**:_____ Date of birth: _____ Age: ____ Sex: ☐ M ☐ F

Address: _____ Social Security Number: _____

City: _____ Medical insurance: ☐ Yes ☐ No

State: _____ ZIP: _____ If Yes, what type: _____

Phone: ( )_____ Dental insurance: ☐ Yes ☐ No

If Yes, what type: _____

If under 18, parent/guardian name: _____ Phone (if different from above): ( )_____

Patient Dental History

Date of last dentist visit: _____ For what service? _____

Dentist seen: _____ Date of last cleaning: _____ Date of last x-rays: _____

Any unhappy dental experiences? ☐ Yes ☐ No Any mouth habits (thumb sucking, nail biting, pacifier, etc.)? ☐ Yes ☐ No

If Yes to any of above, please explain: _____

Brush teeth daily? ☐ Yes ☐ No Floss teeth daily? ☐ Yes ☐ No Have fluoridated water? ☐ Yes ☐ No Have well water? ☐ Yes ☐ No

Please mark (x) if you had any of following problems:

☐ Bad breath
☐ Bleeding gums
☐ Clicking or popping jaw
☐ Food collection between teeth
☐ Grinding teeth
☐ Loose teeth or broken filings
☐ Periodontal treatment
☐ Sensitivity to cold
☐ Sensitivity to hot
☐ Sensitivity to sweets
☐ Sensitivity to biting
☐ Sores or growths in mouth

What is your main dental concern? _____

Patient Medical History

Date of last physician visit: _____ Pregnant? ☐ Yes ☐ No ☐ Not applicable

Physician name: _____ Have child less than 1 year of age? ☐ Yes ☐ No

For what service/reason? _____ Do you smoke? ☐ Yes ☐ No

Do you chew tobacco/snuff? ☐ Yes ☐ No

Please mark (x) if you had any of following problems:

☐ Heart Murmur
☐ Rheumatic Fever
☐ Cancer
☐ Diabetes
☐ Tuberculosis
☐ HIV Positive
☐ Hemophilia
☐ Asthma
☐ Hepatitis
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Drug/Alcohol Addiction
☐ Latex Allergy
☐ Congenital Heart Defect
☐ Mitral Valve Prolapse
☐ Convulsions/Epilepsy
☐ Abnormal Bleeding
☐ Hearing Impairment
☐ Any Operations
☐ Any hospital stay
☐ Kidney/Liver Problems
☐ Handicaps/Disabilities
☐ Other

Please explain any medical problems: _____

Please list all medications currently taking: _____

Please list all allergies or anything (food, drug, or material) you have had a bad reaction to: _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform the office of any change in my/my child's status. I also authorize the dental staff to perform the necessary services I/my child may need.

Signature of patient/parent or guardian: _____ **Date:** _____

Vision Registration Form

Child's Name:_____ **DOB:**_____

Parent's Name:_____

Address: _____
Street City State Zip

Phone:_____ Email:_____

EYE HISTORY:

1. Has your child had an eye exam in the past? YES NO
If so, how long ago? _____

If so, by which eye doctor? _____

2. Have you ever noticed any of the following with your child's eyes?

Eye turn (in or out)	YES	NO
Eyes watering	YES	NO
Eyes red	YES	NO
Swelling around eyes	YES	NO
White appearance in pupil	YES	NO
Frequent rubbing of eyes	YES	NO
Complains of or demonstrates difficulties in seeing	YES	NO

3. Explain any other signs or symptoms noted that you think are unusual

_____

_____

Developmental and Health History

Full Term Birth	YES	NO
Was Oxygen Used	YES	NO

Child's Doctor: _____

List ALL Medications taken regularly: _____

_____

List any eye and/or head injuries/accidents and the age they occurred: _____

_____

List any family members with a history of EYE or MEDICAL problems (along with the problems):

_____

_____

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Household Income Form
(Sheet 3)

Patient Name (*Please Print*)

Household Members:

Number of individuals in household (number of people on tax return): _____

Number of Adults: _____ Number of Children: _____

Household Income:

Name of household member	Type of Income	Amount of Income monthly
	Total	**$**

Signature

Parent signature:

Date:

CVIM Publicity Consent Form

I hereby give Centre Volunteers in Medicine (CVIM), a non-profit provider of free health care, permission to use my or my minor child's likeness in photography for publications, promotional purposes, website, media press releases and coverage, and any other such purpose on behalf of Give Kids a Smile Day.

My signature releases CVIM from any liability caused by blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said pictures, or in any processing thereof.

I understand that I or my minor child (under age 18) will not receive compensation for the use of this likeness in any form.

Description of project: Give Kids a Smile Day and Vision for the Future Programs

Date: _____

Child's Name: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Thank you very much for your participation and supporting CVIM.