NAME OF EVENT – DATE OF EVENT

By signing my name below: I understand that by signing this form I am authorizing a University of Maryland School of Dentistry student and/or faculty member to conduct a basic dental screening, which may include application of fluoride varnish and oral hygiene instruction, on My Child and/or Me. I understand that this screening is only a basic evaluation to help understand My Child's and/or My oral care and does not involve diagnosis or treatment or take the place of a complete dental examination. I understand that I am responsible for arranging follow-up care or services, including a complete dental examination.

I also understand that receiving this dental screening does not establish any new, ongoing or continuing doctor-patient relationship. I am free to establish such a doctor-patient relationship in the future with a dentist of my choice. Further, I will not hold the University of Maryland School of Dentistry faculty or student or other individual conducting or assisting in this screening responsible for My Child's and/or My oral health consequences or results should I choose not to seek follow-up care after today's dental screening

Adult Full Name – Please Print	If Child, Full Name	Adult and/or Child Date of Birth	Adult's Signature (Also for Parent/Guardian Signature)	Parent/ Guardian Date of Birth	Assigned To:

Revised 5/10/13