UNIVERSITY OF THE FRASER VALLEY

UFV DENTAL TREATMENT SCREENING FORM

This form must be completed and signed by a licensed dentist before treatment can be rendered.

TO THE DENTIST:

Our dental assisting students are providing dental services for clients as part of their clinical course. Please examine this client and indicate on this form, which services our students may perform.

Please note:

- **Clients eligible for radiographs are those with either a mixed or permanent dentition**
- ***Client must obtain authorization in compliance with the 60 Day rule.***
- **The client must be calculus free before attending our clinic for coronal polishing**

The UFV Dental Clinic practices in accordance with ALARA radiographic principles.

Client's Name: _____ is eligible to receive the following services:

PLEASE CHECK APPROPRIATE AREAS (✓) and provide additional information where necessary**.**

✓	**UFV SERVICES AVAILABLE** **to be completed by dentist**
	Radiographs
___	• FM Survey
___	• Periapicals Specify teeth: _____
___	• 4 BW's
___	• 2 BW's
___	**Coronal Polishing** Client is calculus free. _____ Was scaled on _____
___	**Topical Fluoride/Varnish**
___	**Fissure Sealants** Specify teeth: _____

**** Treatment must be rendered within 60 days of authorization.***

**** Any radiographs that are taken, will be forwarded via an encrypted email service, to dentist's email address provided below.***

I confirm that I have reviewed this client's medical history and that there are no contraindications, either medical or dental, for the above procedures which I have prescribed.

Dentist's Signature: _____ Date: _____

Dentist's Name: _____ Telephone: _____

Dentist's Address: _____

Dentist Email Address: _____

UNIVERSITY of the FRASER VALLEY
Certified Dental Assistant Program
CONSENT
Minor Child Participation in Certified Dental Assistant Public Clinic

I, _____, of (mailing address) _____

_____

British Columbia, **ACKNOWLEDGE** that I am the legal guardian of the minor child,

_____ (the "Child")

and I voluntarily choose to have him/her participate in the Certified Dental Assistant public clinic (the "Clinic") sponsored by the University of the Fraser Valley (the "University"). I am aware that the purpose of the public clinic is to provide Certified Dental Assistant students with the opportunity to learn proper methods of:

a) polishing clinical crowns and applying topical fluoride (approved by the dentist);
b) taking dental radiographs (approved by the dentist);
c) placing sealants (approved by the dentist);
d) applying desensitizing agents (approved by dentist);
e) providing oral health instructions;
f) other practice sessions ongoing during the clinical course.

I ACKNOWLEDGE that I am aware that the purpose of the screening dentist in his/her scrutiny of my Child's teeth prior to his/her participation in the said Workshop is to determine his/her suitability to receive the limited dental services outlined at (a) to (f) above, and **is not a substitute for regular care by his/her own dentist.**

I am aware that the University is collecting and storing my personal information and that of my Child that I am providing to it in connection with the Clinic. This collection and storage is authorized pursuant to the *University Act* and in accordance with the *Freedom of Information and Protection of Privacy Act*. This information will only be used for the purpose of teaching and education by the faculty and students of the Certified Dental Assisting program at the University. My records may also be reviewed by the CDAC for assessment purposes. Further, I consent to the University disclosing any such personal information with the dentist named on page 1 of this form.

I am aware that participation in the Clinic exposes my child to risks and dangers, which include, but are not limited to, the potential for bodily injury or illness (including contraction of COVID-19); contact or interaction with others who may have been exposed to COVID-19; close proximity to or contact with surfaces, equipment, fixtures, or other objects that, despite the University's efforts, may be infected with COVID-19 or other communicable illnesses (Collectively, "the Risks");

I confirm that I have read this document and that I fully understand it. I also confirm that I understand the Risks of my Child taking part in the Clinic and, notwithstanding those risks, I consent to their participation in the Clinic.

Parent or Guardian Signature: _____

Date: _____