DIAMOND STATE SMILES CLUB
ESC. 2024

I give my permission for Arkansas Oral Health Coalition members to receive the following information as part of my child's participation in the Diamond State Smiles Club:

- Child's name
- Child's age
- Child's county of residence
- Parent/Guardian email address
- Parent/Guardian phone number
- Date of Dental Visit

I understand that my contact information may be used to send oral health education and updates about the Diamond State Smiles Club. I understand I can revoke my permission at any time by contacting diamondstatesmilesclub@gmail.com.

Do you give permission for your child's photo to be used in social media, news media, and/or other outlets if drawn as a contest winner?

☐ **YES**, my child's photo may be used if drawn as a contest winner.

☐ **NO**, my child's photo MAY NOT be used if drawn as a contest winner.

Child Name (Please Print): _____

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____

By typing my name, I understand and agree to the information stated above.

Today's Date: _____

ARKANSAS ORAL HEALTH COALITION
EDUCATION • PREVENTION • ACCESS

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