Dental Program Permission Slip

Teeth-For-Life is offering a preventive dental program for ALL children in your district. A dental provider will come to the school to provide the services. The program includes: dental cleaning assessment to determine if sealants can be done, sealants if appropriate, a fluoride varnish treatment, and oral health education with a new toothbrush. A follow-up letter will be sent home to describe what was completed and what is recommended for future needs. All procedures will follow recommendations from the American Dental Association and Center for Disease Control and Prevention's recommendations for school-based dental sealant programs. This permission slip is effective for two years in order to provide six month cleanings and sealant replacements if necessary.

Child's Last Name: _____ First Name: _____
Date of Birth: ____/____/____ Grade: _____ Teacher: _____
Name of your child's primary dentist: _____

☐ **YES,** I do want my child to participate in school-based oral prevention program and authorize Forward Health to be billed for billable services. Third party insurance companies other than state-offered (such as Badger-Care) will not be billed, nor will the individual. (Please fill out the reminder of the form.)

_____/_____Date: ____/____/____
(Print) parent/guardian (Signature) parent/guardian

☐ **NO,** I **don't** want my child to participate in the school based oral prevention program.

_____/_____Date: ____/____/_____
(Print) parent /guardian (Signature) parent/guardian

Reason for not participating: _____

What type of DENTAL insurance does your child have? _____

☐ Forward Health/Medicaid/BadgerCare ☐ Private Insurance (i.e. Delta Dental) ☐ No Insurance

Please answer the following questions about your child.

1. Does your child use medicine prescribed by a doctor? YES____ NO____
2. If yes, what kind? _____
3. Does your child need/use more medical care than other children the same age? YES____ NO____
4. Does your child have trouble doing things most children the same age can do? YES____ NO____
5. Does your child need or get special therapy, such as physical, occupational, or speech? YES____ NO____
6. Does your child ned counseling or treatment for behavior problems, emotional problems or delays in walking, talking, or activities other children the same age can do? YES____ NO____
7. **If you answered yes to any of the above questions**, has this problem lasted or is it expected to last at least 12 months? YES____ NO____
8. Does your child have any allergies? (i.e. medications, food, latex, tree sap, etc.) YES____ NO____
   If so, please list: _____
9. Has your child been seen by a dentist? **YES, within one year____ YES, > one year ago____ Never____**

The treatment which your child will receive in this program is not meant to be an alternative to regular dental care. It is still strongly recommended that you seek out a dental home (family dentist) for routine dental care including any follow-up care which may be recommended after your child has completed this school based oral health program.