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:		
VES, 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:	Date of Birth:/_	/ Grade:	Teacher:		
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.)	Name of your child's p	orimary dentist:			
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Date:/				dger-Ca	re) will not be
(Signature) parent/guardian NO, I don't want my child to participate in the school based oral prevention program. Date:	billed, nor will the individual.	. (Please fill out the reminder of t	the form.)		
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(Signature) parent/guardian (Signature) 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? 2. If yes, what kind? 3. Does your child need/use more medical care than other children the same age? 4. Does your child have trouble doing things most children the same age can do? 5. Does your child need or get special therapy, such as physical, occupational, or speech? 7. 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? 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? 8. Does your child have any allergies? (i.e. medications, food, latex, tree sap, etc.) YES NO	NO, I don't want my chi	ld to participate in the school ba	sed oral prevention program.		
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If so, please list:	•	, , ,	• • • •	YES	_ NO
	If so, please list:				
9. Has your child been seen by a dentist? YES, within one year YES, > one year ago Never	9. Has your child been s	seen by a dentist? YFS within or	ne vear YFS > one vear ago	Nο	ver

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.