DENTAL SEALANT PERMISSION SLIP – TEMPLATE

Program Name is offering a preventive dental sealant program for ALL children in Insert Targeted Grades . This program is funded by the Wisconsin Seal-A-Smile, a collaborative program of Children's Health Alliance of Wisconsin and the Wisconsin Department of Health Services. A licensed dental provider will come to the school to provide the sealant program at no charge to you. The program includes: assessment to determine if sealants can be done, sealants if appropriate, fluoride treatments and tooth brushing instructions 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 Centers for Disease Control and Prevention's recommendations for school-based dental sealant programs. This permission is effective for Insert Time in order to replace lost sealants when checked after one year or to have sealants applied on teeth that were not sealed this year.

Child Last Name: _____**First Name**: _____ **Date of Birth** _____

Child's Teacher: _____ **Grade**: _____ **Circle one:** **Male** **Female**

◯ **YES,** I do want my child to participate in school-based dental prevention program and authorize Forward Health or any other third party insurance company to be billed for billable services. I give the school permission to share my child's Wisconsin Student ID number with the school-based program.
(Please fill out the rest of the form and return to your child's school)

◯ **NO,** I don't want my child to participate in the school-based dental prevention program. (Sign and return to your child's school)

_____/_____ Date _____
(Print) parent/guardian (signature) parent/guardian

Reason for not participating? _____

What type of DENTAL insurance does your child have? *No student will be refused services based on their insurance coverage*
◯ Forward Health/Medicaid/BadgerCare ◯ Private Insurance (i.e. Delta, Cigna) ◯ No Insurance ◯ Other _____

Ethnicity (select one): ◯ Hispanic ◯ Non-Hispanic ◯ Unknown

Race: (select one) ◯ White ◯ Black/African American ◯ Asian ◯ American Indian/Alaska native
◯ Native Hawaiian/Pacific Islander ◯ Unknown/not available

Please answer the following questions about your child: (Circle one)

1. Does your child use medicine prescribed by a doctor?	YES	NO
If yes, what kind? _____		
2. Does your child need or use more medical care than other children the same age?	YES	NO
3. Does your child have trouble doing things most children the same age can do?	YES	NO
4. Does your child need or get special therapy, such as physical therapy, occupational therapy or speech therapy?	YES	NO
5. Does your child need counseling or treatment for behavior problems, emotional problems, or delays in walking, talking or activities other children the same age can do?	YES	NO
If you selected "yes" to any of the questions (1-5) above: Has this problem lasted or is expected to last at least 12 months?	YES	NO

Does your child have any allergies? (i.e. medications, food, latex, etc.) YES NO
If yes what type? _____

Has your child been seen by a dentist? ◯ Yes, within one year ◯ Yes, over one year ago ◯ Never
Name of your child's primary dentist: _____

Is there anything else about your child you would like us to know?

***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.**