Dental Program Permission Slip

Teeth-For-Life is offering a preventive dental program for ALL children in PreK-6th grade. This program is funded by the Wisconsin Seal-A-Smile, a collaborative program of Children's Health Alliance of Wisconsin and the Wisconsin Division of Public Health Oral Health Program. A dental provider will come to the school to provide the program at no charge to you. 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 Centers for Disease Control and Prevention's recommendations for school-based dental sealant programs. This permission is effective for two years in order to provide six month cleanings and sealant replacements if necessary.

Child Last Name:_____First Name:_____
Date of Birth: ___/_____/_____
Grade:_____Teacher:_____
Name of your child's primary dentist:_____

O **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 BadgerCare, will not be billed, nor will the individual. (Please fill out the remainder of the form.

_____/_____Date___/___/____
(Print) parent/guardian (Signature) parent/guardian

O **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?
O Forward Health/Medicaid/BadgerCare O Private Insurance (I.e. Delta) O No insurance

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, occupational or speech? 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 answered yes to any of the above questions: has this problem lasted or is expected to last at least 12 months? YES NO
6. Does your child have any allergies? (I.e. medications, food, latex, tree sap, etc.) YES NO If yes what type?_____
7. Has your child been seen by a dentist? YES, within one year YES, over 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.**