

# MORE FACTS ABOUT



For Parents  
& Caregivers

A Lee County Health Department dental hygienist will be visiting your child's school to provide **FREE I-Smile™ @ School** dental services soon.

**Please complete, sign, and return the attached consent form or complete the optional e-consent as soon as possible.**

## What free dental services are included?

Dental screening, dental sealants, and fluoride varnish— see more information about each of these services on the next page. Education about the importance of oral health and proper toothbrushing may also be included.

## Can my other children receive free I-Smile™ @ School dental services?

Unfortunately, participation is limited to 2nd grade, sometimes 7th grade, and occasionally 3rd grade in select schools depending on a number of factors. You can ask your school nurse or call the number below to confirm if your child's grade and school will be served.

## Will I receive a report from the dental hygienist?

Yes, a letter will be sent home with your child on the day services are provided and will communicate the following:

- What services were provided
- Any findings of concern
- Recommendations from the hygienist

# NEW!

## E-Consent Option

Go to: <https://is.gd/ISmileAtSchooleconsentLCHD>

Note: url/web address is case sensitive.

Serving Davis, Des Moines, Jefferson, Lee, and Van Buren Counties

Funding for I-Smile™ @ School has been received by the Iowa Department of Public Health.



Contact Information

Rachael Patterson-Rahn, RDH  
Oral Health Program Manager  
Lee County Health Department  
1-800-458-6672



## THE FACTS ABOUT I-Smile™ @ School

### What is I-Smile™ @ School?

I-Smile™ @ School is a preventive dental program that provides no-cost dental screenings, dental sealants, fluoride varnish, and oral health education for students. These services are provided by Iowa licensed dentists and dental hygienists. This preventive dental program takes place during the school day, but students miss very little class time.

### Why is oral health care so important?

Tooth decay (also called cavities) is the most common chronic childhood disease. It is five times more common than asthma and seven times more common than hay fever. Students miss an estimated 51 million hours of school time each year due to dental-related illness.<sup>1</sup> Decay damages teeth and can impact a student's ability to learn, eat and speak properly, sleep, and build self-confidence. Dental sealants and fluoride varnish help protect the teeth and prevent decay. They save time, money and the discomfort often associated with tooth decay.

### What is a dental screening?

A dental screening is a simple look in the mouth to check the condition of the teeth and determine if dental sealants or fluoride varnish are needed. No x-rays are taken, and a dental screening does not take the place of a dental checkup at a dental office.

### What is fluoride varnish?

Fluoride varnish is a sticky liquid that is quickly and easily applied to teeth to strengthen them and prevent tooth decay. It is safe and tastes good. Fluoride varnish is highly effective at reducing a child's risk of decay.



### What are dental sealants?

A dental sealant is a tooth-colored material that is applied to the chewing surfaces of back teeth. Sealants protect teeth from germs and food that can cause cavities. They are very effective at preventing cavities and are recommended by the American Dental Association.

### How are dental sealants applied?

Applying sealants is simple and painless. The teeth are cleaned and the sealant liquid is painted in the grooves of the chewing surfaces with a small brush. The sealant bonds directly to the tooth in about 30 seconds with the use of a special light.

### How long do dental sealants last?

Sealants can last for many years if your child takes good care of his or her teeth. Sealants should be checked at each dental visit and reapplied if necessary.

### When should a child's teeth be sealed?

A child's permanent molars should be sealed as soon as they erupt. These teeth usually come in around the ages of 6 and 12 years. Permanent premolars and primary (baby) molars may also be sealed to protect those teeth from tooth decay.

### How much do these services cost?

All I-Smile™ @ School program services are provided at no cost.

<sup>1</sup> US Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General—Executive Summary. Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.



### Contact information

Bureau of Oral & Health Delivery Systems  
Iowa Department of Public Health  
1-866-528-4020

# Lee County Health Department

## School-Based Dental Sealant Program

### Consent for Services and Release of Information

*Funding for this program serving Davis, Des Moines, Jefferson, Lee, and Van Buren Counties has been received by the Iowa Department of Public Health.*



Child's Last Name	First Name <i>Nickname:</i>	MI	County	Age	Date of Birth	Race(s)
Mailing Address (include city, state, and zip also)			Phone Number(s)  <input type="checkbox"/> OK to text, if needed		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
School Name			Teacher's Name		Grade	
Title XIX ID#, if applicable:			<b>NO PAYMENT FROM YOU IS NEEDED. However, Medicaid (Title XIX) will help cover some of the program costs, so please provide your child's ID number, if applicable.</b>			

**YES**, I give permission for my child to participate in the school-based dental sealant program. I understand my child may receive a dental screening, dental sealants, fluoride varnish application, and oral health education.

**NO**, I do not give permission for my child to participate in the dental program.

- I acknowledge that I may review the Notice of Privacy Practices upon request by contacting Lee County Health Department.
- I understand that this consent is valid for one (1) year unless withdrawn in writing by the parent, guardian, or client (if of legal age).
- I understand that the Iowa Department of Public Health may require retention checks and reapplication, as needed approximately one year after sealant placement.
- I understand that services that will be received do not take the place of regular dental checkups at a dental office.
- I understand that these services are provided under the Iowa Department of Public Health, Maternal, Child, and Adolescent Health Program.
- I understand records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health and its agents and Title V contractors, Iowa Medicaid Enterprise, or designee for audit, preventive health services, and quality improvement purposes or other legally authorized purposes.
- Lee County Health Department complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

**Signature of Parent or Guardian** (I certify I am the parent or legal guardian.) \_\_\_\_\_ **Date** \_\_\_\_\_  
*Please print Parent/Guardian name* \_\_\_\_\_

My signature below indicates that I voluntarily authorize Lee County Health Department to release, obtain, or exchange information as necessary for the purposes of treatment, payment, and health care operations as outlined in LCHD's Notice of Privacy Practices with the following agencies manually and/or via an electronic platform maintained by Signify: Amerigroup Iowa, Inc., Children's Dental Center, Community Health Centers of Southeastern Iowa, community school districts, dentists, Department of Human Services (DHS), hospitals, Iowa Department of Public Health (IDPH), Iowa Medicaid Enterprise (IME), Iowa Total Care, pharmacies, physicians, public health agencies, Title V – Maternal, Child, and Adolescent Health agencies, University of Iowa College of Dentistry, and University of Iowa Hospital and Clinics. This release does *not* authorize disclosure of material protected by federal and/or state law applicable to substance abuse, mental health, and/or AIDS-related information.

**Signature of Parent or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**It is very IMPORTANT that you complete all of the information on the FRONT and BACK of this form:**

1. Does your child have any of the following medical conditions? (check all that apply)
 

<input type="checkbox"/> None Known	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cleft Lip/Palate	<input type="checkbox"/> Hepatitis – Type _____	<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Autism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> ADD	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Vision Impaired
<input type="checkbox"/> ADHD	<input type="checkbox"/> Childhood Obesity	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> PKU	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chronic Ear Infections	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Other Physical or Mental Delay/Disability _____	
			<input type="checkbox"/> Other Condition Not Listed _____	
- If yes, please explain \_\_\_\_\_
2. Has your child ever had any allergic reactions to dyes, foods, or medications?  yes  no  
 If yes, what allergy(ies)? \_\_\_\_\_
3. Is your child taking any medications?  yes  no  
 If yes, what medication(s)? \_\_\_\_\_
4. Does your child have a Doctor or medical office for primary care?  yes  no **If yes, name of Dr./Office** \_\_\_\_\_
5. My child's most recent medical visit for a well child (or adolescent) exam was within the past: (check one)  
 3 months  6 months  12 months  > 1 year  Unknown **Date of last medical exam** \_\_\_\_\_
6. How do you pay for your child's medical care? (check one)  
 Self  Medicaid (Title XIX)  Hawki  Private Medical Insurance  Other \_\_\_\_\_
7. Is your child up-to-date on immunizations?  yes  no
8. Does your child have a dentist?  yes  no **If yes, name of Dentist** \_\_\_\_\_
9. My child's most recent visit with a dentist was within the past: (check one)  
 6 months  1 year  3 years  5 years  Never  Unknown **Date of last dental exam** \_\_\_\_\_
10. How do you pay for your child's dental care? (check one)  
 Self  Medicaid (Title XIX)  Hawki  Private Dental Insurance  Other \_\_\_\_\_
11. Is your child eligible for the free/reduced school lunch program?  yes  no

12. Do you have any questions or concerns about your child's ability to do any of the following? (check all that apply)

- Play             Think             Hear             See  
 Eat             Talk             Move             Other \_\_\_\_\_

Please explain. \_\_\_\_\_  
\_\_\_\_\_

13. Do you have any questions or concerns about your child's teeth or mouth? Please explain. \_\_\_\_\_  
\_\_\_\_\_

14. Has your child ever had any dental problems or injuries to the face or mouth? Please explain. \_\_\_\_\_  
\_\_\_\_\_

15. How long ago was your child's last cavity?  Never     Less than 1 year     1-2 years     More than 2 years

16. What water source(s) does your child drink from? (check all that apply)

- Bottled     City     Rural     Well

17. What source(s) of fluoride does your child have? (check all that apply)

- Toothpaste     Rinse     Supplements (tablets)     Professional treatments from dentist or hygienist     None

18. When does your child brush their teeth? (check all that apply)

- Morning     Midday     Night     After snacks     Not everyday     Never     Other \_\_\_\_\_

19. How often does your child floss their teeth? (check one)

- 1 time daily     1 or more times weekly     1 or more times monthly     Never     Other \_\_\_\_\_

20. Do you need help finding a dentist in your area?  yes     no

*Additional Comments:*

Child's Name	
Date of Birth	
Title XIX #	

I voluntarily authorize Lee County Health Department to use photographs/pictures of my child for the promotion of oral health programs. I understand the photographs/pictures may be used in media formats, such as newspapers as well as social media formats, such as Facebook or presentation formats, such as power point or display boards.

\_\_\_\_\_  
**Signature of Parent or Guardian**

\_\_\_\_\_  
**Date**