PETER CHRISTENSEN DENTAL CLINIC SCHOOL SEALANT PROGRAM

128 Old Abe Rd Lac du Flambeau, WI 54538 (715)588-4269

Peter Christensen School Sealant Program permission slip

Dear Parent/Guardian,

The Peter Christensen Dental Clinic is offering a preventative dental program for the LDF grade school. This program is not meant to be a substitution of regular dental visits.

This program includes:

- Oral health education and tooth brushing supplies
- Oral health assessment by a licensed dental professional (dental hygienist or dentist)
- Dental sealants (where indicated)
- Dental X-rays
- Dental exam
- Fluoride Varnish

If you elect to have your child participate in this program, you will receive a letter describing your child's dental health status and what was completed. All procedures will follow recommendations from the American Dental Association and Centers for Disease Control and Prevention for school-based dental prevention programs.

COMMONLY ASKED QUESTIONS:

Why sealants?

90% of decay in permanent teeth occurs on the chewing surface
Sealants act as a physical barrier to bacteria
They prevent cavities from forming

What is a sealant?

A sealant is a thin, tooth colored plastic coating that is placed on chewing surfaces of permanent teeth. They are placed without altering the tooth itself

What if my child already has sealants?

A dental hygienist of dentist will check your child's sealants
If needed, they will be repaired or replaced

During this field trip media representatives may want to interview, photograph or videotape your child for use in publications, television reports, public presentations and websites. The photographs may be of groups of students or individuals and the students' names may be used.

If you are interested in your child participating, please sign and return the permission slip

PLEASE RETURN TO THE SCHOOL'S FRONT OFFICE

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□ **YES!** I give permission for my child to participate in this program. (Sealants, x-rays, exam, and **I have read the media permission description on the previous page and give permission for my child to be photographed and interviewed and permission to have my child's name used)**

□ **NO.** I do not want my child to participate. (optional) reason for declining?___________

Child's Last Name:__________________First:______________________DOB:__________

Teacher:________________________________Grade:_________________

Parent/Guardian Name:____________________________DOB:______________________

Responsible Party's Mailing Address:____

Phone Number:________________________Email:________________________________

Your insurance will be billed if applicable but no child will be refused services based on their insurance coverage.

What type of **DENTAL** insurance does your child have?

□ Forward Health/Medicaid/BadgerCare □ Private Insurance (i.e. Delta, Cigna) □ No Insurance □Other

Is your child a member of a Federally Recognized Tribe? □ YES or □ NO What tribe? __________

If Enrolled-Tribal Enrollment #: _________________ If 1st Descendant: ___________________

Please answer the following questions about your child. Does your child:

1. Take medicine prescribed by a doctor? **Y/N** If yes, what kind?___________________
   What are these medications taken for?___________________________________
2. Any ongoing significant medical conditions that your child is being treated for? **Y/N**
   If yes what conditions?____
3. Have any allergies (i.e. medications, food, latex)____________________________**Y/N**
4. Has your child ever been seen by a dentist?
   □ Yes, within one year □ Yes, over one year ago □ Never

____

PRINTED PARENT/GUARDIAN NAME SIGNATURE DATE