

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:** _____

Date of Birth: ___/___/___ **Grade:** _____ **Teacher:** _____

Name of your child's primary dentist: _____

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 Badger-Care) will not be billed, nor will the individual. (Please fill out the remainder of the form.)

_____/_____/_____ Date: ___/___/___
(Print) parent/guardian (Signature) parent/guardian

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? _____

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? YES___ NO___
2. If yes, what kind? _____

3. Does your child need/use more medical care than other children the same age? YES___ NO___
4. Does your child have trouble doing things most children the same age can do? YES___ NO___
5. Does your child need or get special therapy, such as physical, occupational, or speech? YES___ NO___
6. 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___
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? YES___ NO___
8. Does your child have any allergies? (i.e. medications, food, latex, tree sap, etc.) YES___ NO___
If so, please list: _____

9. Has your child been seen by a dentist? **YES, within one year**___ **YES, > 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.