



# Please Return whether YES or NO



Walworth County Seal-A-Smile is offering a preventive dental sealant program for **ALL children in grades K4, K5, 2, and 5**. 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 2016 to 2018 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.

I acknowledge that I received a Notice of Privacy Practices

\*\*\*\* **YOU MUST Sign and return this form to your child’s school** \*\*\*\*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 (Print) parent/guardian (signature) parent/guardian Date

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

**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 |
| <b>If yes, what kind?</b> _____  |     |    |
| 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**