WISCONSIN Seal-A-Smile

Return this to your school

OR

Go to https://sealasmile.wisconsin.gov/Consent to sign your child up today!

(IF you already completed this form on paper or online, please disregard)

Healthy Smiles LLC is offering a preventive dental sealant program for children in ALL grades. 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, and fluoride treatments. 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 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:** _____ **M** ___ **F**___ **Date of Birth** ___/___/___
Child's Teacher: _____ **Grade:** _____ **Parent Phone #** _____
Email Address: _____

◯ **YES,** I do want my child to participate and authorize Forward Health (if applicable) to be billed for billable services. . I understand that my child's Health information and Personal Identifiable Information may be shared with appropriate Medical staff, Public Health Staff and Dental staff as needed and appropriate.

(Please complete, sign and return to your child's school)

What type of DENTAL insurance does your child have?
Note: No student will be refused services based on their insurance coverage
○ Forward Health/Medicaid/BadgerCare ○ Private Insurance (i.e. Delta, Cigna) ○ No Insurance ○Other _____

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
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 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 it ok to use your child's photo in newspaper or press release?

◯ **NO,** I don't want my child to participate. **(Sign only and return to your child's school)**
Reason for not participating? _____

_____/_____Date ____/____/____
(Signature) parent/guardian (print) parent/guardian