

Sealants for Smiles
Parent or Guardian Permission Form



For office use only: Student ID: _____

A **FREE** dental program will be in your child's school. This program, which helps prevent tooth decay, is for 2nd and 6th graders. A dentist will examine your child's teeth and decide which teeth need to be sealed. A dental hygienist will then put sealants on your child's teeth to seal out food and bacteria that cause tooth decay. Your child's sealants *may* be checked next year. New sealants will then be placed if needed. Please fill out this form **today**. Your child will take the form to his/her teacher.

IMPORTANT: We need the form signed whether you say Yes or No!

CHILD'S NAME: _____ BIRTHDATE: ____/____/____ MALE FEMALE
 PARENT/GUARDIAN NAME (please print): _____
 HOME ADDRESS: _____ CITY: _____ ZIP: _____
 PHONE: HOME: _____ CELL: _____ WORK: _____
 SCHOOL _____ TEACHER _____ GRADE _____

PLEASE CHECK EITHER YES OR NO then SIGN

- YES**, I want my child to receive **SEALANTS**
 NO, I do not want my child to receive **SEALANTS**.

▶▶▶▶ _____ Date: _____
 Signature of Parent or Guardian

RACE & ETHNICITY: Please check **all that apply** for your child.

- Hispanic Black or African American Native Hawaiian/Pacific Islander
 American Indian/Alaskan Native Asian White Other

HEALTH/DENTAL HISTORY

- YES** **NO** Has your child been to the dentist in the past 6 months? Name of dentist _____
 YES **NO** Has your child ever had any serious health problems? If so please explain: _____
 YES **NO** Does your child have asthma?
 YES **NO** Is your child allergic to latex?
 YES **NO** Is your child allergic to penicillin or other medications? If so, please list _____

Medicaid and other dental insurance, however, help cover the cost of the program. **If you have Medicaid**, CHIP or other dental insurance, please provide the requested information below:

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| <input type="checkbox"/> MEDICAID Please provide the following: Your Child's Medicaid ID# _____ |
| <input type="checkbox"/> CHIP (Children's Health Insurance Program) Please provide the following: Your Child's CHIP ID# <u>1741000</u> _____ or Your Child's Social Security # _____ - _____ - _____ |
| <input type="checkbox"/> Other Dental Insurance - Name of Insurance _____ Please copy the following information as it appears on your CHIP or other Dental Insurance Card: Insured Name _____ and Date of Birth ____/____/____ Member ID # _____ - _____ - _____ |

No payment is required from you for this program.

An explanation of how information about your child may be used and disclosed called Notice of Privacy Practices may be found on our website at: www.sealantsforsmiles.org.