Community Dental Care's School-Based Sealant Program

Dental Sealants at School

PLEASE RETURN FORM BY:

A dental program is being offered in your child's school. A dental team will provide a dental screening and place sealants if appropriate. Sealants are thin, plastic coatings placed on biting surfaces of teeth to help prevent tooth decay and fluoride may also be provided. A report will be sent home to inform you of screening results, services provided, and a dental referral if needed. Sealants placed may be checked 2-24 months after application and reapplied if necessary.

This program does not take the place of a dental examination. Your child should receive a dental exam from his or her dentist at least once a year. Even during a pandemic, it is important to see a dentist. Staff follow Centers for Disease Control and Prevention (CDC) COVID-19 guidelines.

☐ **YES, I want my child to receive SEALANTS!**

This consent form will be required for participation and must be ***completely filled*** *out in order to participate. Fill out both front and back sides, sign the back side, and return the form to your child's teacher.*

☐ **NO, I do not want my child to receive SEALANTS!**

If you do not want your child to participate, please fill in student name only and return form. No additional information is required.

Child's name: ____________________________________

GENERAL INFORMATION: Please provide personal information and health history for participating children.

CHILD'S FULL NAME:________________________________ BIRTHDATE ____/_____/_____ MALE____ FEMALE____

SCHOOL:_________________________________ TEACHER:____________________________ GRADE:_____________

HOME ADDRESS:____PHONE NUMBER:___________________

CITY:_________________________________ STATE:________________ ZIP CODE:_____________________________

RACE/ETHNICITY: _________________________ LANGUAGE SPOKEN AT HOME: ______________________________

RIDES THE BUS_______ WALKS TO/FROM SCHOOL ________ IS PICKED UP_________ STAYS AFTER SCHOOL ______

HEALTH HISTORY: (Please circle **YES** or **NO**)

- **YES / NO** Is your child currently under a physician's care for a problem or illness?
  Please explain____
- **YES / NO** Is your child currently taking any medications?
  Please list medications ____
- **YES / NO** Has your child ever had any serious health problems?
  What was date of incident and please explain____
- **YES /NO** Does your child have any allergies?
  Please list ____
- **YES/NO** Does your child have regular dental exams?
  When was your child's last dental visit? ____

Complete Back Side of Form - If any information is left blank, we may not be able to see your child.

INSURANCE INFORMATION: No payment is required from you. Payment from Minnesota Health Care Programs and other insurance plans helps to cover the cost of this program.

☐ **My child is covered by Minnesota Health Care Programs. Circle the insurance plan and fill in the ID numbers.**

ID #/Member # ________________________ PMI#(Health Partners/DentaQuest/UCare ____________________

☐ **My child is covered by another dental insurance plan not listed above:**

Plan Name _____________________________ Insurance Phone # _____________________________________

Policy Holder's Name ______________________________ Policy holder's Birthdate ______________________

ID #/Member #/PMI # ____________________________________ Group # _____________________________

☐ **My child has no dental insurance. I would like the sealant cost to be covered by scholarships/ grants.**

EMERGENCY CONTACT INFORMATION: Please provide name and phone number of person to contact in case of an emergency.

Contact Name: ___________________________________ Phone number: ___________________________

Relationship to student: ____________________________

CONSENT TO TREATMENT

I give Community Dental Care and the School-Based Sealant Program permission to provide dental screenings and preventative services including fluoride treatment and dental sealants; to collect payment from Medical Assistance or private insurance; to allow the dentist to obtain my child's dental screening records; to allow the school nurse to obtain my child's dental screening records; to use dental records for treatment and billing purposes; and to contact me to provide health care information about treatment, payment, my insurance, or my account.

By signing this form, I consent for my child to participate in the School-Based Sealant Program. I have received a copy of Community Dental Care's Notice of Private Practices. I am aware that a copy of the Notice of Privacy Practices is also available for me to view at the school nurse's office. I am aware that staff are unable to maintain a distance of six feet. Consent is valid for 24 months to provide follow-up services.

Name of parent/guardian (please print): ____

Signature of parent/guardian: ____ Date: _________________

If you have questions about Community Dental Care's School-Based Sealant Program, please call (651)-478-4703 Ext.2206 and ask to speak with Kali Tiernan Sealant Program Manager.

Funding for this program was made possible by grants from National Children's Oral Health Foundation, Park Dental Foundation, Minnesota Department of Health, and Delta Dental of Minnesota Foundation.

*** Please note: No payment is required from participating families. Minnesota Health Care Programs and other insurance plans will be billed as appropriate for preventive services. This reimbursement helps to cover the cost of this program.