Free Dental Sealant Program

Please Sign and Return This Form

A free dental program will be in your child's school. An area dentist will screen your child's teeth and decide which teeth need to be treated. Those teeth will be coated with a plastic sealant. Sealants help prevent tooth decay by sealing out food and bacteria that cause decay. **This is not intended to replace your regular exams at your dental office.**

*_____**YES**, I want my child to receive a dental screening and sealants. **(Please fill out the entire form as accurately as possible)**

*_____**NO**, *I do not* want my child to receive a dental screening or sealants. **(Only fill out child's name and sign at bottom or form)**

Name of Child_____
First **Middle** **Last**

Date of Birth_____/_____/_____ **[ ]Male [ ]Female** **Home # _____**
Cell # _____

School_____ **Teacher** _____ **Grade** _____

Home Address_____ **City**_____ **Zip**_____

Race/Ethnicity (Check all that apply):
[ ] White **[ ]** Black/African American **[ ]** Hispanic **[ ]** Asian **[ ]** American Indian/Alaskan Native **[ ]** Pacific Islander

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Brief Health History

1. Is your child currently under a physician's care? Yes / No
2. Is your child currently taking any medications? Yes / No
3. Has your child ever had any allergic reactions to dyes, foods or medications? Yes / No
   Please explain any **YES** answers:_____
4. Do you have a regular family dentist? Yes / No Name: _____
   County of provider: _____
5. My child's most recent dental visit was with the last: [ ] 6 months [ ] 12 months [ ] 3 years [ ] 5 years [ ] Never seen a dentist
6. How do you pay for your child's dental care? [ ] Self [ ] Medicaid/Title 19 [ ] *hawk-i* [ ] Private dental insurance [ ] Other
7. If you have private dental insurance have you checked with your provider to see if sealants are covered? Yes/No
8. List any problems now or recently with your child's teeth._____
9. Do you or anyone in the home have cavities now? Yes/No
10. How many times does your child eat snack foods, or sugary, sticky foods or drinks each day? _____
11. Does your child carry something around to drink (other than water) at home? Yes/No
12. Does your child drink fluoridated water, take fluoride supplements or use toothpaste with fluoride in it? Yes/No
13. Does your child brush at least 2 times a day and floss regularly? Yes/No
14. Who is your child's doctor? Name:_____
15. Can your child see this doctor for check-ups and sickness? Yes/No Date of last visit: _____
16. Does your child have medical insurance? [ ] Self [ ] Medicaid/T19 [ ] *hawk-i* [ ] Private medical insurance [ ] Other
17. Is your child eligible for free/reduced cost lunch program at school? Yes/No
18. Would you like information mailed to you about the *hawk-i* insurance program? Yes/No

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***Please check with your private insurance provider (through employer or private plan) on whether your policy covers sealants. If sealants are not covered your child is eligible for this program. Children with Title 19 coverage are eligible for this program. *hawk-i* coverage will cover sealants at your private dental provider.**

- I understand that these services are provided under the Iowa Department of Public Health (IDPH), Maternal and Child Health Program.
- I understand records created and maintained as part of this program are the property of IDPH and may be shared with IDPH, Iowa Department of Human Services (DHS), dentists or designee.
- I understand records are available to the DHS for auditing purposes.
- I understand that this consent is valid for one year upon the date of signature.

PARENT OR GUARDIAN_____ **Date**____/____/____
(sign)

Please print parent/guardian name _____

Please return this to your child's teacher within 3 days. Thank you.