

## Free Dental Sealant Program-Henry County

Dear Parent, /Guardian

A **free** dental program for 3<sup>rd</sup> & 7<sup>th</sup> graders will be in your child's school. An area dentist will screen your child's teeth and will 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 as follow-up letters will go home afterwards. Answers will remain confidential)**

\*      **NO**, *I do not* want my child to receive a dental exam or sealants. **(Only fill out child's name and sign)**

**Name of Child** \_\_\_\_\_

**Date of Birth**      /      /           **First**      **Middle**      **Last**  
**Medicaid # (if have)** \_\_\_\_\_      **Male**           **Female**     

**School** \_\_\_\_\_      **Teacher** \_\_\_\_\_      **Grade** \_\_\_\_\_

**Home Address** \_\_\_\_\_      **City** \_\_\_\_\_      **Zip** \_\_\_\_\_      **Home Phone** \_\_\_\_\_

### **HEALTH HISTORY**

- |  |          |                                |
|--|----------|--------------------------------|
| 1. Is your child currently under a physician's care? | YES / NO | Reviewed (for office use only) |
| 2. Is your child currently taking any medications?   | YES / NO | _____                          |
| 3. Has your child ever had any allergic reactions?   | YES / NO | _____                          |

Please explain any **YES** answers: \_\_\_\_\_

\*If you have private insurance (through a place of employment or private company) and are unsure whether your policy covers sealants, check with your provider. If it doesn't cover, you are eligible for this program. Title XIX coverage are eligible for this program.

### **No payment is required from you for this Program.**

- I understand that these services are provided under the Iowa Department of Public Health, Maternal and Child Health Program.
- I understand records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health, Bureaus of Family Health or Oral Health or designee.
- I understand records are available to the Department of Human Services for auditing purposes.

### **Racial and Ethnic Information *(Please check all that Apply)***

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

**Do you have a regular family dentist? Yes or No** If yes, whom? \_\_\_\_\_ and where do they practice?  
\_\_\_\_\_

**Does your child see the dentist at least once per year? Yes or No**

**My child's most recent dental visit was within the last: (please check one)**      6 months        12 months        3 years  
     5 years        Has never seen a dentist

**How do you pay for your child's dental care?** (Check all that apply.)      Self        Medicaid/Title XIX        Hawki  
     Private dental insurance        Other

**Does your child have Medical insurance?** (Check all that apply.)      Self        Medicaid/Title XIX        Hawki  
     Private medical insurance        Other

**Do you have a regular family doctor? Yes or No** If yes, whom? \_\_\_\_\_ and where do they practice?  
\_\_\_\_\_

**Is your child eligible for free/reduced cost lunch program at school? Yes or No**



**PARENT OR GUARDIAN** \_\_\_\_\_ **Date**      /      /     

(sign)                      (consent is good for 12 months from above date for retention checks)

Please print parent/guardian name also \_\_\_\_\_

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