

(grantee name)

DENTAL SEALANT PROGRAM

Dear Parent,

A **free** dental program will be in your child's school. This program, which helps prevent tooth decay, is for second and sixth graders. A dentist will examine your child's teeth and decide which teeth need to be sealed. A dental hygienist will then put the sealants on your child's teeth to seal out food and bacteria that cause decay. Your child's sealants will be checked next year. New sealants will then be applied if needed. Please fill out this form **today**. Your child must return it to his/her teacher.

PLEASE CHECK EITHER YES OR NO

- YES** I want my child to receive **SEALANTS**. (Please fill in the entire form, sign below and return form.)
 NO, I do not want my child to receive **SEALANTS**. (Please fill in name, sign below and return form.)

CHILD'S NAME _____	BIRTHDATE ____/____/____	MALE ___	FEMALE ___
SCHOOL _____	TEACHER _____	GRADE _____	
CHILD'S SOCIAL SECURITY NUMBER _____	PHONE _____		

ETHNICITY: Is your child Hispanic? (Please check) **YES** **NO**

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

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

Does your child get free or reduced price meals at school? (Please check)

- YES** **NO** **Don't know/don't remember**

HEALTH HISTORY

Has your child ever had any serious health problems? (Please check) **YES** **NO** If **YES**, please explain _____

Does your child have any of the following allergies? (Please check)

Acrylic/plastics **YES** **NO**

Other **YES** **NO** If **YES**, please list _____

No payment is required from you for this program. However, the value of this service is more than \$150 per child and we rely on insurances such as Medicaid or Healthy Start to help cover the costs. If your child is covered by Medicaid/Healthy Start, **please check** the name of his/her Managed Care Plan and fill in the ID numbers.



(Managed Care Plan logo)

(Managed Care Plan logo)

(Managed Care Plan logo)

Managed Care ID# _____ MEDICAID # (12 digits) _____



SIGNATURE of parent or guardian _____ **DATE** _____

Did you receive the **Notice of Privacy Practices**? (Please check) **YES** **NO** If yes, **initial** here _____