

Healthy Smiles



F O R P O R T A G E C O U N T Y

Portage County Health and Human Services

817 Whiting Ave. Stevens Point, WI 54481

Phone: 715-345-5781

PLEASE RETURN TO TEACHER BY: TOMORROW

WHETHER PARTICIPATING OR NOT

Healthy Smiles for Portage County is offering a preventive dental sealant program for ALL children in 2nd and 6th–9th grades. All 2nd grade students will receive a dental screening and participate in classroom education. All 2nd grade students that return a positive permission slip will be eligible for services. All 6th–9th grade students that return a positive permission slip will be eligible for a dental screening and services. This program is funded in part by Wisconsin Seal-A-Smile, a collaborative program of Children’s Health Alliance of Wisconsin and the Wisconsin Department of Health Services.

A licensed dental provider will come to the school to provide the sealant program at **no charge to you**. The program will make several visits to the school throughout the school year and includes: assessment to determine if dental cleanings or sealants are appropriate, sealants if appropriate, fluoride treatments, dental cleanings if appropriate and tooth brushing instructions with a new toothbrush. A follow-up letter will be sent home after each visit to describe what was completed and what is recommended for future needs. All procedures will follow recommendations from the American Dental Association and Centers for Disease Control and Prevention’s recommendations for school-based dental sealant programs.

The treatment your child will receive in this program is not meant to be an alternative to regular dental care. If your child does not have a dentist, it is strongly recommended that you seek out a dental home (family dentist) for routine dental care including any follow up care which may be recommended after your child has completed this school based oral health program.

In order for your child to receive services the back side of this form must be filled out, signed and returned to your child’s teacher.

Name of Child _____ Teacher/School _____ / _____ Grade _____

_____ **NO**, I don’t want my child to participate in the school-based dental prevention program.

(Sign and return to your child’s school)

Reason for not participating? _____

Parent/Guardian’s Signature _____ Date _____

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Health History/Permission Slip

 YES, I do want my child to participate in school-based dental prevention program and authorize Forward Health or any other third party insurance company to be billed for billable services (You will not have to pay any co-pays or deductibles). This permission is effective for 2 school years in order to replace lost sealants when checked after one year or to have sealants applied on teeth that were not sealed this year. I give the school permission to share my child's Wisconsin Student ID number with the school-based program. (Please fill out the rest of the form and return to your child's school)

Name of Child _____ Teacher/School _____ / _____ Grade _____

Date of Birth _____ Gender: Male _____ Female _____

Address _____ Zip _____

Home Phone _____ Work/Cell Phone _____

Ethnicity (select one): Hispanic Non-Hispanic Unknown

Race (select one) White Black/African American American Indian/Alaska native
 Asian Native Hawaiian/Pacific Islander Unknown/not available

Does your child (check Yes or No):

Use medicine prescribed by a doctor? Medication _____ Yes _____ No _____

Need or use more medical care than most children the same age? Yes _____ No _____

Have trouble doing things most children the same age can do? Yes _____ No _____

Need or get special therapy, such as physical therapy, occupational therapy or speech therapy? Yes _____ No _____

Need counseling or treatment for behavior problems, emotional problems, or delays in walking, talking, or other activities that other children the same age can do? Yes _____ No _____

If you checked yes to any of the above:

Has this problem lasted or is it expected to last at least 12 months? Yes _____ No _____

Does your child have any allergies, physical problem or disease we should be aware of? Yes _____ No _____

Please Explain _____

What type of DENTAL insurance does your child have?

Note: No student will be refused services based on their insurance coverage. You will not have to pay any copays or deductibles for this program.

Forward Health/Medicaid/BadgerCare No Dental Insurance

Private Dental Insurance (i.e. Delta, Cigna)

Has your child been seen by a dentist? Yes, within 1 year _____ Yes, over 1 year ago _____ Never _____

Dentist Name _____

Healthy Smiles may consult with or notify your child's dentist of services to be provided to assure consistent dental care.

Parent/Guardian's Signature _____ **Date** _____