PERMISSION FORM: School-Based Dental Health Program

Please complete this form and return to your school. Form valid for 1 year from date of consent.

Name of Student: _____ Child's Date of Birth: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____

Phone (home and/or cell phone): _____ Email: _____

School: _____ Teacher: _____ Grade: _____ Age: _____

☺ **YES,** I do want my child to participate in the school-based dental health program and authorize Forward Health or any other third party insurance company to be billed for billable services. **You and your school will NOT be billed for these services**.

*(Please fill out "*Health History*" section below if your child is participating).

_____ _____ _____

(Signature) Parent/guardian (Print) parent/guardian Date

⊘ **NO,** I do not want my child to participate in the school-based dental health program (Ignore "Health History" below if not participating).

_____ _____ _____

(Signature) Parent/guardian (Print) parent/guardian Date

Reason(s) for not participating: _____

*Health History

No student will be refused services based on their insurance coverage.
This program is free to all students.

What type of DENTAL insurance does your child have?

☐ Forward Health/ Medicaid/ BadgerCare ☐ Private Insurance (i.e. Delta, Cigna)
☐ No Insurance ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Not Applicable

Race (check all that apply): ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Not Applicable

1. Does your child use medicine prescribed by a doctor? ☐ YES ☐ NO
   Please list prescribed medications: _____
2. Does your child need or use more medical care than other children the same age? ☐ YES ☐ NO
3. Does your child have trouble doing things most children the same age can do? ☐ YES ☐ NO
4. Does your child need or receive special therapy, such as physical therapy, occupational therapy or speech therapy? ☐ YES ☐ NO
5. Does your child need counseling/treatment for behavior or emotional problems, or have delays in walking, talking or activities other children the same age can do? ☐ YES ☐ NO
6. **Regarding Questions #1 - #5** above, have any of the prescription(s), condition(s), or therapy lasted at least 12 months (or expected to last more than 12 months)? ☐ YES ☐ NO
7. Please list any allergies your child has (i.e. medications, food, latex, etc.): _____
8. Has your child been seen by a dentist? ☐ Yes, within one year ☐ Yes, over one year ago ☐ Never

   Name of your child's primary dentist/dental office: _____

***This school-based dental program is provided by Seals-On-Wheels Oral Health Program (www.SealsOnWheelsWisconsin.com). The preventative service offered is not meant to be an alternative to regular dental care. It is strongly recommended that you seek out a family dentist for routine dental care, including any follow-up care which may be suggested during your child's participation in this dental program. All dental services are carried out in a confidential manner, and your health information privacy is respected in accordance with the Health Insurance Portability and Accountability Act (HIPAA: http://www.hhs.gov/ocr/privacy/). Questions about the program? Call Nikki L. Frisch, RDH, at 608-988-6472 or email SealsOnWheelsWI@gmail.com.*