

□ SCHOOL: \_\_\_\_\_

Teacher: \_\_\_\_\_

## Seal! Michigan: Dental Sealant Program for Grades: 1<sup>st</sup>, 2<sup>nd</sup>, 6<sup>th</sup> & 7<sup>th</sup>.



**FREE! FREE! FREE!**

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This **FREE** sealant program can help protect your child from developing cavities in their permanent molars. Permanent molars are the most vulnerable to cavities, because of all the grooves present on the surface of the tooth, so it is very important to protect those teeth with sealant. A very thin coating will be applied to the child's back teeth.

Please consider this safe, effective, and **FREE** treatment for your child!

### Parent/Guardian Consent

Child's Legal Name \_\_\_\_\_  
First Middle Last

Child's Grade: \_\_\_\_\_

**Yes**, I want my child to have:

- A dental screening by a licensed dental hygienist, **SEALANTS** placed on his/her permanent molars (if they are needed), a **FLUORIDE TREATMENT** and follow-up sealant check within the school year.
- Sealants rechecked and repair any chipped or missing areas.

**No**, Please return form to school even if you say no.

**I understand that if I have insurance or Medicaid, they will be billed for this service. I will be required to provide all insurance information, including social security numbers to receive this service. If I do not have insurance, I will still receive the service free of charge. I will pay no out of pocket costs, at any time for this service. Please note: The provider may submit a claim to insurance. If your insurance does not cover sealants, the child can still have sealants.**

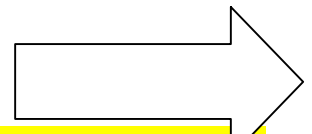
Required Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name of Parent/Guardian \_\_\_\_\_ Relationship to Child \_\_\_\_\_

\*\*\*\*\* Return form to school tomorrow \*\*\*

**If you chose yes above, please complete the BACK of this form.**

**EVENT DATE:** \_\_\_\_\_



**Questions Contact: Smiles on Wheels 517-740-7422, smiles on wheels@hotmail.com**

Your child's personal information will be kept confidential and will not be shared with any person who is not directly involved in the care of your child as part of the Health Insurance Portability and Accountability (HIPAA). It is understood that if false information is given, that this may disqualify my child from receiving sealants.

**PLEASE PRINT CLEARLY IN INK.**

Child's Legal Name \_\_\_\_\_  
First Middle Last

Child's Gender:  Male  Female Child's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Child's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Parent/Guardian Phone \_\_\_\_-\_\_\_\_-\_\_\_\_ Cell Phone \_\_\_\_-\_\_\_\_-\_\_\_\_ E-mail Address \_\_\_\_\_

In an Emergency Contact \_\_\_\_\_ Emergency Phone # \_\_\_\_\_

Do you have dental insurance?  Yes  No- If **NO** would you like Michigan Primary Care Association assistances in enrollment for insurance?  Yes  NO.

Child's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (# CONFIDENTIAL)

Insured Parent's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (# CONFIDENTIAL)

Child's Medicaid, Healthy Kids Dental/MI Child ID # (If applicable) \_\_\_\_\_

Check **dental** insurance that you have:  Medicaid  Healthy Kids Dental  MI Child  Delta Dental  Blue Cross  
 Other Insurance Give name \_\_\_\_\_

Name of **Insured Adult** Under Whom Child is Covered: \_\_\_\_\_ Insurance Group #: \_\_\_\_\_  
Policy/Id # \_\_\_\_\_

Place of employment \_\_\_\_\_ Birth date of Insured Adult \_\_\_\_/\_\_\_\_/\_\_\_\_

Does your child participate in Free and Reduced School Lunch Program?  Yes  No

Smiles on Wheels has my permission to take photos of my child for educational or promotional purposes.  Yes  No

Child's Ethnic/Racial Background: (Check all that apply):  White  Black/African American  Asian  Hispanic  
 American Indian/Alaska Native  Native Hawaiian/Pacific Islander  
 Other

**Child's Health History:**

Has your child visited a dentist for a dental cleaning in the past 6 months?  Yes  No

Dentist's name \_\_\_\_\_

If **NO**, would you like your child to receive a dental cleaning today?  Yes  No

Is your child taking any medication?  Yes  No If yes, name of medication \_\_\_\_\_

Does your child have allergies (such as latex or food)?  Yes  No If yes, what is child allergic to? \_\_\_\_\_

Is child under the care of a physician?  Yes  No If yes, explain \_\_\_\_\_

Does your child have learning or emotional impairment?  Yes  No

Please check any conditions that your child has:  TB  Asthma  Seizures/Convulsions  Hepatitis  Diabetes  
 Rheumatic Heart Disease  HIV Aids  Hearing  Artificial Joints

Has your child had any serious health conditions not mentioned above?  Yes  No

If yes, please explain \_\_\_\_\_ Physician's Name \_\_\_\_\_

Funding and support for this program has been received from the Michigan Department of Community Health, Oral Health Program 517-335-9526.

Office Use Only: Date \_\_\_\_\_ Sealants Placed # 2 3 14 15 18 19 30 31 Varnish Yes No Prophy Yes No  
Provider's Initials \_\_\_\_\_  \_\_\_\_\_