

Waushara County Shara Smile



Waushara County is offering a preventative dental sealant program for ALL students in 2nd, 5th & 7th grades. This program is funded by the Wisconsin Seal-A-Smile, a collaborative program of Children's Health Alliance of Wisconsin and the Wisconsin Division of Public Health Oral Health Program. A Registered Dental Hygienist will come to the school to provide the sealant program at **no charge to you**. The program includes: assessment to determine if sealants can be done, sealants as needed, a fluoride treatment and tooth brushing instructions with a new tooth brush. A follow-up letter will be sent home 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. This permission is effective for two years in order to replace any lost sealants when checked after one year or to have sealants applied on teeth that were not sealed this year.

Child's First and Last Name: _____ **Grade:** _____

Date of Birth: _____ **Child's Teacher:** _____ **School:** _____

Name of child's primary dentist: _____

Has your child been seen by a dentist? ___ YES, within the past year ___ YES, over a year ago ___ Never

___ YES, I do want my child to receive dental sealants

___ YES, I do want my child to receive fluoride varnish (3 applications)

___ NO, I do not want my child to receive dental sealants

___ NO, I do not want my child to receive fluoride varnish

Reasons for not participating? _____

What type of Dental Insurance does your child have?

Note: No Student will be refused services based on their insurance coverage

___ Forward Health/Medicaid/BadgerCare ___ Private Insurance ___ No Insurance

Race/Ethnicity (optional): ___ White ___ Black/African American ___ Hispanic ___ Asian
___ American Indian/Alaska Native ___ Native Hawaiian/Pacific Islander ___ Other

Please answer the following questions about your child: (Circle One)

1. Does your child use medicine prescribed by a doctor? YES NO **If yes, what?** _____
2. Does your child need or use more medical care than other children the same age? YES NO
3. Does your child have allergies? (medication, food, latex, etc.) YES NO **If yes, what type?** _____
4. Does your child have trouble doing things most children the same age can do? YES NO
5. Does your child need or get special therapy, such as physical, occupational or speech? YES NO
6. Does your child need counseling or treatment for behavior or emotional problems, or delays in walking, talking or activities other children the same age can do? YES NO

If you selected "yes" to any of the questions above:

Has this problem lasted or is expected to last at least 12 months? YES NO

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_____ **Date** _____

Parent/guardian signature

I authorize MA/Forward Health (when applicable) to be billed for billable services.

Information on the Waushara County Privacy Notice which describes how medical information about your child may be used and disclosed can be found on the Waushara County Health Department Website at <http://www.co.waushara.wi.us> **The treatment which your child will receive in this program is not meant to be an alternative to regular dental care. It is still strongly recommended that you seek out a dental home (family dentist) for routine dental care including follow-up care which may be recommended after your child has completed this school based oral health program.