Dear Parent or Guardian:

Hudson River HealthCare offers a special preventive dentistry program for your child at school. The program consists of placing dental sealants on your child's teeth as well as a follow-up evaluation, dental education, and fluoride varnish or fluoride rinsing. Dental sealants prevent cavities by sealing out the bad bacteria that cause tooth decay. Fluoride is a mineral that prevents cavities by coating the outside surfaces of teeth to make the hardest part of our teeth even stronger. It can be added to tooth enamel by rinsing and spitting with a fluoride mouth rinse each week or by coating teeth with a thin layer of fluoride varnish four times a year.

If your child's molars (back teeth) contain deep grooves where they chew but have no cavities, they can benefit from receiving dental sealants. We first clean these teeth with a special paste. Next, we wash off the paste with water and apply a special gel that allows the dental sealants to stick to the teeth. Finally, we wash off the special gel, dry the teeth, and apply the dental sealant. In future years, your child will receive a check up to make sure the sealants are still strong.

Being a part of this preventive program is totally up to you, and you may stop your child at any time. If you wish to ask your dentist for their advice, please so do **before** returning this permission form with your signature.

In order to allow us to provide dental care for your child in our school-based program, your written consent is needed.
WE NEED YOU TO PLEASE FILL OUT ALL OF THE INFORMATION BELOW. THANK YOU.

School-Based

Dental Program Consent Form

School: _____ Teacher:_____ Grade:____

Child's Name: _____ DOB (date of birth):_____ Gender: (Male/Female)_____

Parent/Guardian Name: _____

Home Address: _____

Home Phone: _____Work Phone: _____Cell Phone:_____

___No, I do not want my child to participate in program at this time.
___Yes, I want my child to receive dental sealants.

I understand that if I have dental insurance for my child, up to date insurance information is required to receive these dental services. I give permission to HRHCare to bill my insurance company for any services rendered that are covered by my insurance plan. I understand that if my insurance does not cover the services, HRHCare will still provide services to my child at no charge to me.

[HRHCare is required under the Health Insurance Portability and Accountability Act (HIPPA) to provide each parent/guardian with a copy of this information. It is also required that you acknowledge receipt of this information.]

Signature: _____Date:_____

____My child has no insurance at this time

Name of Insurance: _____Insurance ID/CIN#:_____Group#:_____

Do you have a **family dentist**? If yes, their name and address: _____

Does your child have a **chronic medical condition(s)** like diabetes, asthma? Yes___ No___ Condition(s)_____

Does your child require **antibiotics** before they receive any dental care? Yes___ No____ Antibiotic(s)_____

Does your child take any **daily medications**? Yes_____ No_____ If Yes, what are they taking?_____

Does your child have any **allergies** to: **Medications:** Yes____ No____ Medications: _____
Tree Nuts: Yes____ No_____ **Peanuts:** Yes____ No_____

Has your child ever had?
Asthma: Yes ____ No ____ **Heart Murmur:** Yes ____ No ____

Hepatitis: Yes ____ No ____ **Rheumatic Fever:** Yes ____ No ____

Tuberculosis: Yes ____ No ____

Thank you for completing this form for your child to participate in HRHCare's school-based preventive dental program.

Please do not separate the white and yellow sheets of paper of this form.
Please return to the school nurse. 02/13