

Free School Sealant Program Permission Slip



Free dental screenings and sealant services are now offered at your child's school. Dental sealants are plastic coatings put on the back teeth and are a quick and easy way to prevent cavities. The screening and sealants are done by dental care professionals.

Name of Child: _____		
(Last)	(First)	(Preferred Name)
Student's Date of Birth (mm/dd/yy): ____ / ____ / ____ Teacher: _____ Grade: ____		

YES, I want my child to have a dental screening and dental sealants.

**Even though your child may have received sealants last year, please mark yes so we can check them.*

If yes, please complete and sign below

Contact Information	
Parent/Guardian:	
Best phone number to reach you: _____	Permission to Text: <input type="checkbox"/> Yes <input type="checkbox"/> No
Email address: _____	
Mailing address: _____	

Please provide the following information so we can better serve your child:

My child is taking (list medications):	None: <input type="checkbox"/>
My child is allergic to:	None: <input type="checkbox"/>
Any current medical problems:	None: <input type="checkbox"/>
Any behavioral considerations:	None: <input type="checkbox"/>
Other information to help us better serve your child:	None: <input type="checkbox"/>

Please complete the section below. You will not receive a bill.

Health Insurance: <input type="checkbox"/> Oregon Health Plan (OHP) / Medicaid ID# _____ <input type="checkbox"/> Private dental insurance company _____ <input type="checkbox"/> No health insurance	These services are FREE!
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By signing below you:

As the legal parent/guardian, I hereby consent to the release and exchange of information, including any relevant personal health information, between the dental sealant staff, school staff, insurance carriers, the child's dentist, applicable Coordinated Care Organization, and/or the Dental Care Organization of record. I have received a copy of "Notices of Privacy Practices." I also understand a dental student closely supervised by a licensed dental professional may provide treatment.

Parent/Guardian Signature: _____ **Date:** _____