

INFORMED CONSENT—DENTAL SEALANTS/FLUORIDE VARNISH/DENTAL CLEANING (PROPHY)

*** PLEASE RETURN THIS FORM TO YOUR CHILD'S TEACHER***

Child's Name : _____ Male _____ Female _____ Date of Birth _____
(Last First MI)

Child's School: _____ Name of Teacher: _____ Grade: _____

Yes, I do want my child to participate in school based dental prevention program and I authorize Forward Health and any other third party insurance company to be billed for billable services (please fill out the rest of the form)

CONSENT: I have read, or have read to me, and understand the information on this form. I hereby give my free and informed consent to the Menasha Health Department for a) an examination by a licensed dentist/registered dental hygienist to determine the need for dental sealants, dental cleaning and/or fluoride varnish treatment if necessary b) the application of fluoride varnish, dental sealants or performance of a dental cleaning by a registered dental hygienist c) performance of retention checks and repair and reseal of teeth if necessary by a registered dental hygienist This permission is effective for two years

Signature of Parent/Guardian: _____ Date _____

Home Phone Number: _____ - _____ Work Phone Number: _____ - _____

No, I do not want my child to participate in school based prevention programs.

Signature of Parent/Guardian: _____ Date _____

If your child is participating in the prevention program please answer the questions below.

Race: **(circle all that apply)** White, African American, Asian, Pacific Is. Native American, Hispanic , other _____

What type of Dental Insurance does your child have?

Forward Health/Medicaid/BadgerCare Private Insurance (ie Delta, Cigna) No Insurance Other _____

Note no student will be refused services based on their insurance coverage

Does your child (check YES or NO):

Use medicine prescribed by a doctor? yes no

Need or use more medical care than other children the same age? yes no

Have trouble doing things most children the same age can do? yes no

Need or get special therapy, such as physical therapy, occupational therapy or speech therapy? yes no

Need counseling or treatment for behavior problems, emotional problems, or delays in walking, talking, or activities that other children the same age can do? yes no

If you checked any of the boxes above:

Has this problem lasted or is expected to last at least 12 months? yes no

List prescription medicines your child takes on a regular basis: _____

The Following Questions help to determine the number of Fluoride treatments your child may need

Does your child take prescription fluoride supplements? yes no

Does your child drink city, well or bottled water? _____

Has your child received any fluoride treatments in the last year? yes no **If yes, when** _____

Has your child seen a dentist in the last year? yes no Date of last visit _____

Circle All That Apply

Does your child have Asthma, Breathing Problem?

If your child has allergies please list what he/she is allergic to. _____

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 any follow up care which may be recommended after your child has completed this school based oral health program

Wisconsin SEALS Child-Level Data Collection Form

1. Program Name: _____ 2. Event/Site Name: _____
 3. Patient Name: First _____ Last _____
 4. ID #: _____ *Each child's ID # must be unique for that event; do not use duplicate ID #'s at any one event.
 5. Sex: _____ (0 = Male, 1 = Female) 6. Grade: _____ (0 = Kindergarten) 7. DOB _____ 8. Age: _____
 9. Race/ethnicity (Check all that apply): _____ White _____ Black/African American _____ Asian _____ Hispanic
 _____ American Indian/Alaska Native _____ Native Hawaiian/Pacific Islander _____ Other
 10. Special health care needs: _____ (0 = No, 1 = Yes)
 11. Medicaid/SCHIP status _____ (0=Medicaid, 1=SCHIP, 2=Uninsured, 3=Private Insurance, 99=Unknown)

I. Screening — **D** = decay, **F** = filled, **M** = missing, **S** = sealant present, **PS** = prescribe sealant,
RS = recommend reseal, **no mark** = no treatment recommended

1	2	3	4	5	12	13	14	15	16	Sealant Prescriber's Signature

										Date _____
32	31	30	29	28	21	20	19	18	17	Fluoride Prescriber's Signature

										Date _____

Comments: _____

12. Untreated Cavities: 0 = No untreated cavities 1 = Untreated cavities present	13. Caries Experience: 0 = No caries experience 1 = Caries experience	14. Sealants Present: 0 = No sealants 1 = Sealants present
15. Treatment Urgency: 0 = No obvious problem 1 = Early dental care 2 = Urgent care	16. Referred for treatment: 0 = No 1 = Yes	17. Decayed or filled teeth: a. 1 st molars <input style="width: 40px; height: 20px;" type="text"/> b. 2 nd molars <input style="width: 40px; height: 20px;" type="text"/>

II. Preventive Services - Mark the teeth where sealants were placed with an S.

1	2	3	4	5	12	13	14	15	16	Provider's Signature

										Date _____
32	31	30	29	28	21	20	19	18	17	

Comments: _____

18. Number of teeth sealed among: a. 1 st molars <input style="width: 40px; height: 20px;" type="text"/> b. 2 nd molars <input style="width: 40px; height: 20px;" type="text"/> c. other <input style="width: 40px; height: 20px;" type="text"/>	19a. Fluoride treatment received: 0 = none 1 = varnish 2 = gel/foam/rinse	19b. # of varnish applications <input style="width: 40px; height: 20px;" type="text"/>	Varnish application dates & provider initials 1) _____ 2) _____ 3) _____
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III. Follow-Up - Mark teeth where sealants were retained with an R.

1	2	3	4	5	12	13	14	15	16	Evaluator's Signature

										Date _____
32	31	30	29	28	21	20	19	18	17	

Comments: _____

20. Number of teeth retaining a program sealant: <input style="width: 40px; height: 20px;" type="text"/>	21. Subsequent visit for restorative treatment: 0 = No 1 = Yes 99 = Unknown, no follow-up performed by program
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For Office use Only

Date _____ Amount Billed _____
 Date _____ Amount Billed _____
 Date _____ Amount Billed _____
 Date _____ Amount Billed _____

Codes

D1206 = Fluoride Varnish
 D1351 = Sealant
 D0191 = RDH Exam
 D0120 = DDS Exam
 D1120 = Child Prophy

Overall assessment of the child's dental caries risk: High Moderate Low