

Free Dental Decay Prevention Program

(Please sign this form and return it to school immediately.)

Dear Parent,

A free dental program will be in your child's school. The program helps stop tooth decay. A dentist will examine your child's teeth. The dentist will decide which back teeth need to be treated. Those teeth will be coated with a plastic **sealant**. **Sealants** seal out food and bacteria which cause decay.

Your child may also be examined next year. New **sealants** will be put on if needed. Please fill in this form today. Your child will take it back to his/her teacher. We need the form if you say Yes or No.

_____ **YES**. I want my child to receive **SEALANTS**. (Please fill in the entire form and sign at the bottom.)

_____ **NO**. I do not want my child to receive **SEALANTS**.

Name of Child _____ Date of Birth ____/____/____

Male _____ Female _____ Race _____ School _____

Teacher _____ Room _____ Grade _____

Home Address _____ Zip _____ Home Phone _____

★ **PARENT OR GUARDIAN** _____ (Sign) Date ____/____/____

▶▶▶ _____ By initialing here, I acknowledge receipt of the Agency's Notice of Privacy Practices.

HEALTH HISTORY

	Yes	No
1. Has your child had heart surgery? If yes, please explain _____ _____	1. _____	_____
2. Has your child had any other serious health problems? If yes, please explain _____ _____	2. _____	_____

No payment is required from you for this Program. Medicaid and other insurance, however, help cover the cost of the program. If you have Medicaid or other insurance, please check the one you have:

Ohio Medicaid Health Card

careSource

CHIP (Children's Health Insurance Program)

Other

Healthy Start/ Healthy Families

Please copy the following information as it appears on your card:

<small>(Member Name)</small>	<small>(Member ID Number)</small>	<small>(Suffix)</small>	<small>(Social Security Number)</small>

Social Security # ____/____/____

★ **PARENT OR GUARDIAN** _____ (Sign) Date ____/____/____