



School-based Dental Sealant Grant

Parent or Guardian Consent Form

A free portable dental program will soon be in your child's school. A Public Health Dental Hygienist will screen & place preventive dental sealants on your child's back molars. This screening is not to take the place of a regular dental check up.

_____ **YES**, I give permission for my child to receive a dental screening and sealants, along with a 6 month follow up screening to check for sealant retention.

_____ **YES**, I also give permission for my child to receive a fluoride varnish treatment to help strengthen tooth enamel and prevent decay.

_____ **NO**, I do not give permission for my child to receive a dental screening, sealants, or fluoride.

If you wish for your child to receive services, you MUST sign and date below!

*By signing below (1) I give HACAP permission to perform the services checked above, (2) I understand that these services are provided under the Iowa Dept. of Public Health and the records created and maintained as a part of this program are the property of the IDPH, (3) I understand that the information from these records may be shared with your child's school nurse, the IDPH, the Dept. of Human Services office and your child's dentist and/or physician, and (4) HACAP Privacy Policy is available upon request. This form will remain in effect for one (1) year from the date of signature below.

X _____
*Parent/Guardian Signature Date

Child's name (last, first)			
Title 19 ID Number (If Applicable)	DOB	Age	County
Parent's Name (printed)			
Address	City	Zip	
Daytime/Cell Phone:	Evening Phone:	Male <input type="checkbox"/> Female <input type="checkbox"/>	
School	Teacher/Grade		
Race (Please circle one): White Black Hispanic Asian/ Pacific-Islanders Native American Unknown Other			

Please answer the following Health & Dental questions about your child:

1. Does your child have a doctor? ___ yes ___ no If yes, Doctor name: _____
2. Is your child currently under a physician's care? ___ yes ___ no Explain yes: _____
3. Does your child have any medical conditions? ___ yes ___ no List: _____
4. Is your child currently taking any medications? ___ yes ___ no List: _____
5. Has your child had any allergic reactions? ___ yes ___ no Explain yes: _____
6. Does your child have a latex allergy? ___ yes ___ no Explain yes: _____
7. Is your child eligible for free/reduced lunch? ___ yes ___ no
8. Does your child have a dentist? ___ yes ___ no If yes, Dentist name: _____
9. My child's most recent dentist visit was within the last: (please check one)
 ___ 6 months ___ 12 months ___ 3 years ___ 5 years ___ has never seen dentist
10. How do you pay for your child's dental care? (please check one)
 ___ self ___ medicaid/Title19 ___ hawk-l ___ private dental insurance ___ other

NO PAYMENT IS NEEDED FOR THIS SCREENING & SEALANT PROGRAM