Florence County Health Dept.
P.O. Box 17
Florence, WI 54121

Forest County Health Dept.
200 E. Madison Street
Crandon, WI 54520

Oneida County Health Dept.
P.O. Box 400
Rhinelander, WI 54501

Vilas County Health Dept.
330 Court Street
Eagle River, WI 54521

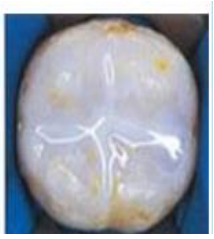
Northwoods Dental Project

Seal-A-Smile

PARENTS:

All 2nd and 6th grade students are eligible to receive Oral Health Exams, Dental Sealants, Fluoride Varnish & Dental Supplies at NO COST.

Tooth without a sealant



Tooth protected with sealant

Dental sealants are a thin plastic like coating painted onto the chewing surfaces or grooved areas of the back teeth or molars. Sealants protect these grooves by "sealing out" bacteria and food. With proper care like tooth brushing and dental visits, ***sealants are nearly 100% effective in preventing cavities*** on these surfaces and can last up to 10 years. Applying sealants is safe, simple, and painless. If you think your child already has sealants on their teeth they can still be checked as the sealant may need to be repaired or more teeth may be present to seal.

Fluoride Varnish is simple, painless and only takes a couple minutes to apply. After the teeth are checked, a thin layer of fluoride varnish is painted on the teeth and dries almost immediately. The varnish leaves a coating of fluoride that remains on the teeth until brushed or wiped off after 6 hours and little to no fluoride is ingested. For best results, fluoride varnish will be applied 2-3 times throughout the school year.

***Did you know…*Children receiving dental sealants have 60% less new cavities in their back teeth*.** **Protect your child's teeth today!**

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To Participate:

Please fill out the ***Permission Form*** printed on the ***BACK*** of this sheet & ***return to your child's school*** by the return date listed.

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VIDEO

For more about the Wisconsin Seal-A-Smile program or Northwoods Dental Project please view their videos at: http://www.vilaspublichealth.com/dentalservices.html#northwoods-dental-project

All programs are school-based and take place at your child's school. If problems are identified during your child's dental screening by one of our dental professionals, you will be notified of the need for follow-up dental treatment. Our HIPAA Policy can be viewed on our website under Northwoods Dental Project at www.vilaspublichealth.com. If you would like a written copy of our HIPAA Policy mailed to you, please contact us with your name and address. For more information about this oral health program or other oral health programs Northwoods Dental Project offers, please call: 715-479-3758 or visit your county health department website. *Centers for Disease Control and Prevention. (2013). Preventing Dental Caries with Community Programs. Retrieved from http://www.cdc.gov/oralhealth/publications/factsheets/dental_caries.htm

Northwoods Dental Project

Seal-A-Smile

PERMISSION FORM
Seal-A-Smile Program

WISCONSIN Seal-A-Smile

Please complete & return with YES or NO to school by: November 27, 2017

Northwoods Dental Project is offering a preventive dental sealant program for ALL children in 2nd and 6th grades. This program is funded by the Wisconsin Seal-A-Smile, a collaborative program of Children's Health Alliance of Wisconsin and Wisconsin Department of Health Services. A licensed dental provider will come to the school to provide the sealant program at no charge to you. The program includes: assessment to determine if sealants can be done, sealants if appropriate, fluoride treatments and tooth brushing instructions with a new toothbrush. A follow-up letter will be sent home to describe what was completed and what is recommended for future needs. All procedures follow the American Dental Association and Centers for Disease Control and Prevention's recommendations for school-based dental sealant programs. This permission is effective for 2 years in order to replace any lost sealants or to apply sealants on new teeth not sealed last year. **Child Last Name:** _____ **First Name:** _____ **Date of Birth** ____/____/____

Child's Teacher: _____ **Grade:** _____ **Sex: F M** **Age:** _____

Mailing Address: _____ **City:**_____ **Zip:** _____

Phone/Home: _____ **Cell:** _____ May we text you if necessary? ____Yes _____No

◯ **YES,** I want my child to participate in school-based dental prevention program and authorize Forward Health or any other third party insurance company to be billed for billable services. I give the school permission to share my child's Wisconsin Student ID number with the school-based program. **(Please sign and fill out the rest of the form below and return to your child's school)**

_____/_____Date _____/_____/_____

(Print) parent/guardian (Signature) Parent/guardian

◯ **YES,** My child can have their picture taken and I understand it may be used for local, county or state promotional purposes.

_____/_____Date _____/_____/_____

(Print) parent/guardian (Signature) Parent/guardian

◯ **NO,** I don't want my child to participate in the school-based dental prevention program. (Sign and return to your child's school)

_____/_____Date_____/_____/_____

(Print) parent/guardian (Signature) parent/guardian

Reason for not participating? _____

1) What type of DENTAL insurance does your child have? Note: No student will be refused services based on their insurance coverage: ◯orward Health/Medicaid/BadgerCare ◯rivate Insurance (i.e. Delta, Cigna) ◯o Insurance ◯ther _____

2) Ethnicity (select one): ◯ Hispanic ◯ Non-Hispanic ◯ Unknown

3) Race (select one): ◯ White ◯ Black/African American ◯ Asian ◯ American Indian/Alaska native ◯ Native Hawaiian/Pacific Islander ◯ Unknown/not available

Please answer the following questions about your child: (Circle one)

A. Do you have a home well water system? YES NO

B. Does your child use medicine prescribed by a doctor? YES NO **If yes, what kind?** _____

C. Does your child need or use more medical care than other children the same age? YES NO

D. Does your child have trouble doing things most children the same age can do? YES NO

E. Does your child need or get special therapy, such as physical therapy, occupational therapy or speech therapy? YES NO

F. Does your child need counseling or treatment for behavior problems, emotional problems, or delays in walking, talking or activities other children the same age can do? YES NO

If you selected "yes" to any of the questions (B-E) above: Has this problem lasted or is expected to last at least 12 months? YES NO

4) Does your child have any allergies? (i.e. medications, food, latex, etc.) YES NO If yes what type? _____

5) Has your child been seen by a dentist? ◯ Yes, within one year ◯ Yes, over one year ago ◯ Never

Name of your child's primary dentist: _____

***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.**