

School: _____

Teacher Name: _____

Grade: _____

School Based Dental Sealant Program - Parent Permission Form

Questions? Call Community Health Care's Dental Coordinators: (253) 210-5294 or (253) 722-1551

Community Health Care (CHC) is a non-profit dental care provider selected by Tacoma-Pierce County Health Department to offer convenient, preventive dental services at school. With your permission a registered Dentist **will screen your child, provide oral hygiene education, tooth brushing instructions, and apply sealants and fluoride varnish**. We will notify you of our findings and help refer your child to a dentist if needed. Schedule permitting, we will return within the school year to ensure that the sealants remain intact and to complete another fluoride varnish as appropriate. *This service will not conflict with the regular 6-month check-up your child receives with their family dentist.*

Student's Name _____ Birth Date _____ / _____ / _____
First Middle Initial Last (if using 2 last names, please include both)

Parent/Guardian _____ Birth Date _____ / _____ / _____
First Middle Initial Last (if using 2 last names, please include both)

Address _____ City/State/Zip _____ Phone _____

What is your child's sex? ☐ Male ☐ Female

What is your child's ethnic background? ☐ Hispanic ☐ non-Hispanic

What is your child's race? ☐ Asian/Pacific Islander ☐ Black/African American ☐ Caucasian ☐ Native American ☐ Multi-Racial
☐ Other _____ ☐ Prefer not to Report.

Medical History Please mark any health conditions your child currently has or has had in the past:

☐ Currently no health concerns ☐ Asthma ☐ Latex Allergy ☐ Other Allergies _____
☐ Epilepsy/Seizures ☐ Diabetes ☐ Heart Problem ☐ Any other health concerns? _____

Child's Dentist's Name (if applicable) _____ Date of Last Visit _____ / _____ / _____

Please check one of the options and complete the information **CHC will bill insurance, but not you.**

☐ **Washington Apple Health/Medicaid:** Please provide child's 9-digit number from the Provider One/Washington State Services Card.

ID # _____ WA

☐ **Private Insurance:** Insurance name _____

Subscriber Name _____ Birthdate _____ / _____ / _____

Subscriber ID # _____ Group or Policy # _____

Insurance Address _____ Insurance Phone _____

☐ **None:** My child is not currently covered by any dental insurance. Allow my child to participate through the donated services your program offers. Also, please send me information regarding Washington State Apple Health/Medicaid. **No child turned away due to inability to pay!**

MY CHILD HAS PERMISSION TO RECEIVE **AN ORAL HEALTH ASSESSMENT, FLUORIDE VARNISH, AND/OR DENTAL SEALANTS** DURING THIS SCHOOL YEAR "I authorize Bethel School District to release my child to Community Health Care staff during the school day(s) identified above, for the performance of any of the dental services herein identified, and further authorize my child's school district to provide this consent form to the Tacoma-Pierce County Health Department and Community Health Care."

→ **Parent/Guardian Signature (Required)** _____ Date _____ / _____ / _____

Community Health Care adheres to all Health Insurance Portability and Accountability Act 1996 (HIPAA) standards. We are committed to protecting the privacy of your child's health information. The HIPAA requires all health care records to be kept confidential. By signing above, we have your permission to communicate with your child's school district's health staff regarding your child's dental needs and health care information.

FOR OFFICE USE ONLY

Dentist Signature _____ Date _____ / _____ / _____