24-25 SEAL-A-SMILE REGISTRATION FORM

Community Health Systems (CHS) is offering a preventative dental program for ALL children in all grades. Funding is received by Wisconsin Seal-A-Smile, a collaborative program of Children's Health Alliance of Wisconsin and the Department of Health Services. A licensed dental hygienist will come to the school to provide sealants, fluoride varnish, tooth brushing instructions and possibly a dental cleaning. The care received is not meant to be an alternative to regular dental care. A dental home is recommended for routine dental care, including any follow up care that may be recommended via a letter that will be sent home after my child has received their visit. All procedures follow American Dental Association and Centers for Disease Control recommendations for school based dental sealant programs. This permission is effective for 24 months. HIPAA policy may be viewed at: https://rebrand.ly/nppesp Call 608-361- 0311 if questions or email sas@chsofwi.org.

CHILD INFORMATION							
Child Name	(Last)		(First)			Child DOB	/ /
Gender	M F Other	School		Grade		Teacher (If known)	
Ethnicity	Hispanic Unknown Non-Hispanic	Race	White Black/African American Unknown Asian American Indian/Alaska Native Native Hawaiian/Pacific Islander			Family Income (not required to report) $_____	
Dental Insurance	Forward/Medicaid Private Unknown No Insurance	Has your child been seen by a dentist?	Within a year Over a year Never		Dentist Name	_____	
Is there anything about your child you would like us to know? If Yes, explain.							

PARENT GUARDIAN INFORMATION/AUTHORIZED SIGNATURE			
Parent/Guardian Name	(Last)	(First)	
Phone #		Email	
Address		City	Zip

☐ **YES**, my child can participate without my presence. There is no charge to participate. I authorize billing to Forward Health or any third-party insurance company. If a bill is received, contact CHS at the above number and do not pay. If I choose to withdraw this consent, I must provide a written note explaining this to CHS Seal-A-Smile

Parent/Guardian Signature		**Date**	
☐ NO, don't include my child. (Please let us know why so we can better serve you in the future.			

HEALTH HISTORY		
List out any allergies		
1. Does your child use medicine prescribed by a doctor?	Yes	No
List out medications		
2. Does your child need or use more medical care than other children the same age?	Yes	No
3. Does your child have trouble doing things most children the same age do?	Yes	No
4. Does your child need/get special therapy, such as physical, occupational or speech therapy?	Yes	No
5. 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 (1-5) above: Has this problem lasted or is it expected to last at least 12 months?	Yes	No