**Preventive Dental Care at School**

**[Insert Health Department Here]**

**Your child can get free preventive dental care while at school**

With your permission, a dental hygienist will provide your child with:

•A dental assessment of the condition of the mouth and teeth

•An age-appropriate dental cleaning

•Fluoride Varnish (prevents future cavities on the smooth surfaces of teeth)

•Dental Sealants (long-lasting plastic coatings over the cavity-prone grooved surfaces of back teeth)

•Oral Hygiene Instruction including nutritional counseling

•Referral Sheet with Community Dentists

In future years, your child’s sealants will be checked to make sure they are still on the teeth. If needed, new sealants will be placed.

This program does not take the place of regular check-ups at a dental office. The preventive dental services are being doing by a Public Health Registered Dental Hygienist without the on-site presence of a dentist, according to KRS 313.040. The Dentist Board member for your county is , who is supportive of the standards of practice of the public health hygienists and work with your Board of Health to develop and adopt protocols for these services.

Check One:

⃝Yes, I want my child to have preventive dental services at school

⃝No, I do not want my child to have preventive services at school

Parent/Legal Representative Name (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Representative Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daytime Phone:

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male Female

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher/Homeroom Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your child have a dentist? Circle one: Yes No
2. When was the last time your child went to the dentist? Circle one:

In the past year More than one year ago Never

1. Does your child have: Circle one:

Medicaid Dental Insurance No Dental Insurance

ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List your child’s (general) health problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What is your child’s race: (check one or more)

⃝ American Indian/Alaskan Native ⃝ Pacific Islander

⃝ Asian ⃝ White

⃝ Black or African American Ethnicity: ⃝ Hispanic or Latino