Patient Name:

DOB:

MR #:

Index to Patient Participation Agreement

Date: _____

Access Community Health Centers
2901 West Beltline Highway, Ste 120, Madison, WI 53713

FLUORIDE VARNISH PERMISSION SLIP

Celebrate Smiles
Access Community Health Centers

Celebrate Smiles is a program that offers free dental services for all children in 4K to 8th grade. This program is run by Access Community Health Centers with support from community partners.

Services
All services will follow the American Dental Association and Centers for Disease Control and Prevention's recommendations for school-based dental programs. A licensed dental provider will come to the school to provide:

- fluoride treatment,
- tooth brushing instructions, and
- screening for future dental services.

Follow Up
A follow up letter will be sent home to describe what your child had done during this visit. It will also list recommendations for your child's future needs. This permission is valid for 18 months in order to apply 2-3 total fluoride treatments.

Child's Last Name	Child's First Name	Date of Birth
Child's Teacher		Grade
Check one: ☐ Male ☐ Female ☐ Nonbinary ☐ X		

☐ **YES**, I do want my child to participate in the school-based dental prevention program. I 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 dental prevention program. *(Please fill out the rest of the form and return to your child's school)*

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

What type of dental insurance does your child have? No student will be refused services based on their insurance coverage or lack of insurance coverage.

☐ Forward Health/Medicaid/BadgerCare ☐ Private Insurance (i.e., Delta, Cigna) ☐ No Insurance

☐ Other:_____

Ethnicity (select one): ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race (select one): ☐ White ☐ Black/African American ☐ Asian American
☐ Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Unknown/Not Available

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FLUORIDE VARNISH PERMISSION SLIP

Please answer the questions below about your child:

1. Does your child have any allergies (i.e., medicines, food latex, etc.)? ☐ Yes ☐ No

   If yes, what type? _____

2. Has your child been seen by a dentist? ☐ Yes, within one year ☐ Yes, over one year ago ☐ Never

   Name of your child's dentist: _____

3. Does your child use medicine prescribed by a doctor? ☐ Yes ☐ No

   If yes, what kind? _____

4. Does your child need or use more medical care than other children the same age? ☐ Yes ☐ No
5. Does your child have trouble doing things most children the same age can do? ☐ Yes ☐ No
6. Does your child need or get special therapy, such as physical therapy, occupational therapy, or speech therapy? ☐ Yes ☐ No
7. 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 questions 3-7 above, please answer the below question:

Has this problem lasted or is expected to last at least 12 months? ☐ Yes ☐ No

Is there anything else about your child you would like us to know?

Signature of Patient/Representative: _____ Date: ____/____/____ Time: _____

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

- Patient is: ☐ Minor ☐ Incompetent/Incapacitated
- Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Health Care Agent ☐ Other: _____

Reviewed by: _____ Date: ____/____/____ Time: _____

**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.*