Parents,

The Northeast Colorado Health Department’s School-Based Oral Health Program provides prevention services to help stop tooth decay for school-aged children. Because northeast Colorado is considered an underserved area when it comes to oral health, these services are provided free of charge.

This program is not intended to replace regular dental checkups and cleanings, but it is a convenient opportunity to have your child seen while they’re at school. If you would like for your child to participate, follow the instructions inside and complete the permission slip. If you have additional questions, please contact Tina Kohl at (970) 522-3741 x 1237 or tinak@nchd.org

Tooth decay is nearly 100% preventable, yet it is the most common chronic childhood disease.

Poor oral health can affect your child’s ability to learn, eating habits, speech development, activity level and self esteem.
Dental screening
Each child has their teeth and the soft tissue in their mouths evaluated by a dental hygienist. Our hygienists are making sure there is no decay or need for other dental services.

Fluoride varnish
Children receive a fluoride varnish, which is painted on all of their teeth by a dental hygienist. This varnish helps protect their teeth and can be reapplied every three months.

Dental sealants
Children will have sealants applied to their first or second molars. Sealants are a thin plastic coating that protects those teeth. They are also painted on by a hygienist on the first molars, which typically erupt in 2nd grade, and on second molars, which typically erupt in 6th or 7th grade.

Educational instruction
Children receive education regarding proper brushing techniques, basic oral hygiene, cavity prevention and good nutrition.

Participation is easy!

1. Ask staff when a clinic will be at your school or call NCHD, (970) 522-3741 x1237.

2. Read and detach the HIPAA notice and sign the permission slip so your child can receive services. Only children who turned in signed permission slips receive treatment. Detach and send it in!

3. Detach the signed permission slip and send it back to school with your child.

*To help keep this program sustainable, dental insurances such as Medicaid and CHP+ who reimburse for school-based dental screenings, fluoride varnish, and sealants by hygienists may be billed. Parents/guardians will not be responsible for any co-pay.

We will keep a record of your child’s dental services so that we can provide good ongoing care. We will share our records with the Colorado Department of Public Health to track the services we provide, but will not share your name or your child’s name.
I ______________________________ give permission for my child named below to have the following services provided as deemed necessary by the dental professional:

**Educational instruction:** Proper brushing and oral hygiene  
**Fluoride varnish:** A protective treatment for the teeth  
**Dental screening:** An evaluation of the teeth and soft tissue  
**Sealants:** A protective barrier placed on molars, sealants will be checked the following school year for retention

(Please check the services you would like your child to receive)

I understand that these services are considered to be preventive in nature and other restorative treatment may be deemed necessary by the oral health provider. I understand that if my child requires further treatment, the oral health provider/health department staff will help me understand my options for treatment and methods for payment. Some options for payment may include Medicaid, CHP+, government grants, as well as other programs that are or may become available to my child.

Student Name: __________________________________________ Date of Birth: ______________________
School: ___________________________ Grade: ____________________ Teacher: ___________________________
Student ID number (if known) _________________________________________________________________
Parent/ Guardian Name: _________________________ Relationship to Child: ___________________________
Mailing Address: __________________________________________________________________________
City: __________________________________________ State: __________ Zip: _________________________
Contact Number: (     ) _____________ Dental/Medical Provider: __________________________/ __________

If provided, a copy of screening results may be sent to primary care providers as part of NCHD’s medical home initiative

Has your child seen a dentist within the last 12 months? Yes / No If yes, when?___________________

I furthermore give permission to photograph, videotape or record my child and to use their likeness in Northeast Oral Health Project program print and electronic materials.

Check here if you do not want your child photographed.

☐

Dental Insurance: ☐ Medicaid #_________________________ ☐ Private
☐ CHP+ #_________________________ ☐ Not Insured

Has your child ever had allergies? Yes ____ No ____ To what: _______________________________________

Other serious health problems? Yes ____ No ____ If “yes” please explain: _______________________________________

I hereby authorize providers for the Northeast Oral Health Project to release to my insurance company or its representative any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental services. I also authorize and request my insurance company to pay directly to providers of the Northeast Oral Health Project the amount due me in my pending claim for preventative dental services. Furthermore, I authorize providers of the Northeast Oral Health Project to correspond with the Insurance Commissioner on my behalf should this become necessary. When available, all services rendered will be billed to my insurance carrier. Permission slips are valid for one calendar year.

Parent/Guardian Signature: ___________________________________                          Today’s Date: ______________________

If you have questions regarding information in this packet, please contact Penny at (970) 522-3741 x 1254

☐ I acknowledge receiving the Northeast Colorado Health Department HIPAA notice.

This permission slip must be signed and returned to the school in order for your child to receive services.