



Bad River Health & Wellness Center
Dental Clinic
 53585 Nokomis Road
 Ashland, WI 54806-4272

Smiles on Wheels PERMISSION SLIP

Bad River Dental Clinic – Smiles on Wheels (BRDC-SOW) is offering a preventive dental sealant program for **ALL American Indian/Alaska Native (AI/AN) children** in **grades K-12 of the Ashland Area Schools**. A licensed dental provider will come to the school to provide the sealant program at no charge to you. **The program includes:** dental assessment, sealant application if needed, fluoride treatments, and oral health instruction. A letter will be sent home with your child to describe what was completed and what is recommended for future needs. All procedures follow recommendations from the American Dental Association and the Center for Disease Control and Prevention for school-based dental sealant programs.

Childs Name: _____ **Grade:** _____ **Teacher:** _____

Childs Date of Birth: ____/____/____ **Age:** _____ **Sex:** Male or Female

Contact phone: _____

YES, I do want my child to participate in school-based dental prevention program and authorize Forward Health or any other third party insurance – company to be billed for billable services.

(Please fill out the rest of the form and return to your child’s school)

_____/_____/____ Date ____/____/____
 (Print) parent/guardian (signature) Parent/guardian

NO, I don’t want my child to participate in the school-based dental prevention program. (Sign and return to your child’s school)

_____/_____/____ Date ____/____/____
 (Print) parent/guardian (signature) parent/guardian

Reason for not participating? _____

1) What type of DENTAL insurance does your child have?

Note: No student will be refused services based on their insurance coverage

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

Dental Insurance Company _____ **Insurance ID #** _____
Card holder name _____ **Card holder date of birth** _____

****To comply with federal confidentiality regulations, we must ask for permission annually.

Please answer the following questions about your child: (Circle one)

A. Does your child have any physical or mental issues? YES NO If yes, please explain _____

B. Does your child have any allergies? YES NO If yes, to what? _____

Name of your child’s primary dentist: _____

The treatment which your child will receive in this program is not meant to be an alternative to regular dental care. It is recommended that you seek a regular dental office for routine dental care, including any follow-up care which may be recommended after your child has completed this school-based oral health program.

We encourage you to reenroll your child every year to monitor their oral health needs.