SEAL! Michigan Dental Sealant Program / Fluoride Program

Dear Parent or Guardian,

Your child's school, in cooperation with the Michigan Department of Health and Human Services and the **Ottawa County Department of Public Health,** is offering a program to help stop tooth decay in your child's teeth.

1. Who can receive free sealants?
   - **all** 2nd, 6th and 7th grade students at your child's school
2. When and where does sealant placement take place?
   - at your child's school
   - during school hours
3. If my child has a dentist, can he/she still sign up?
   - YES! Sealants are not always done in a dental office
4. Does the SEAL! Michigan Program replace regular dental visits?
   - NO! Your child should still see a dentist every 6 months
5. How do I sign my child up for no cost sealants?
   - complete attached blue form
   - return in attached envelope to child's teacher
6. Is my information kept private?
   - YES! This program will be carried out in a confidential manner
7. Who can answer more questions?
   - Kacie at (616) 393-5771

Sincerely,

Ottawa County Department of Public Health

SEAL! MICHIGAN

SEAL! MICHIGAN DENTAL SEALANT PROGRAM

Free Dental Sealant Program / Fluoride Program

For **2nd, 6th and 7th** grade students

OTTAWA COUNTY DEPARTMENT of PUBLIC HEALTH **616-393-5771**

12251 James St. Suite 400 Holland, MI 49424

PLEASE RETURN THIS FORM TO YOUR CHILD'S TEACHER IN THE ENVELOPE PROVIDED

This program does not take the place of regular dental check-ups at a dental office.
It is intended for children who need sealants and otherwise would not have access to these services.

Child's School:			Teacher:		Grade:
Child's Name:	First	Middle	Last	Sex	Birth Date
Parent's (Guardian)Name			Home phone	Work phone	Cell phone
Address		City	State	Zip	

In an Emergency, contact:
Emergency Contact Name: Emergency Phone #:

INSURANCE / FINANCIAL INFORMATION

1. Does your child participate in the Free and Reduced Lunch Program? ☐ Yes ☐ No **2.** Do you have dental insurance? ☐ Yes ☐ No
3. If your child has Medicaid or other insurance, please check the appropriate box: ☐ No insurance ☐Medicaid/Healthy Kids Dental ☐MI Child ☐Delta Dental ☐Other insurance, please name: _____
4. Child's Social Security # _____ Provider ID # _____
5. Have you applied for Medicaid coverage for your child in the last 90 days? ☐ Yes ☐ No

Information of Private Dental Insurance: If duplicate services are obtained elsewhere; it may affect benefits that your child receives from private insurance, a state or federal program, or a third party provider.

6. Name of Dental Insurance Company _____
Policy # _____ Plan ID or SS# _____ Group# _____
7. Name of Policy Holder: _____ Birth Date: _____ Relationship to Insured _____
8. Policy Holders Address: ☐ Check if same as child _____
9. Name of Employer(company):

Ethnic/Racial Background (Please check all that apply): ☐White ☐Black/African American ☐Asian ☐Hispanic ☐American Indian/Alaska Native ☐Native Hawaiian/Pacific Islander ☐Arab or Arab American ☐Other

HEALTH HISTORY

Does your child have or has your child had? (please check yes or no)

Tuberculosis (TB)	☐YES	☐NO	
Latex Allergy	☐YES	☐NO	
Hepatitis	☐YES	☐NO	
Asthma	☐YES	☐NO	
Allergies	☐YES	☐NO	To what?
Seizures/Convulsions	☐YES	☐NO	
Cognitive/emotional impairment	☐YES	☐NO	
Other serious health problems	☐YES	☐NO	Please explain
Does your child take medication?	☐YES	☐NO	If Yes, please list

Physician's name: _____ Physician's Phone Number: _____
Dentist or dental office that provided dental services in the past 12 months: _____

AUTHORIZATION

Consent: I, _____ (please print parent name), give permission for my child (above mentioned) to take part in the SEAL! Michigan Dental Sealant Program. I give permission for the dentist or dental hygienist to provide a basic dental screening, to place dental sealants on my child's teeth if they are needed, to provide a fluoride treatment and to check whether the sealants are still present after they were placed. The provider may submit a claim to Medicaid, Healthy Kids Dental, MI Child or my insurance. I understand that my child's personal information will be kept confidential and will not be shared with any person who is not involved directly in the care of my child as part of the Health Insurance Portability and Accountability Act (HIPAA). I understand that consent can be revoked at any point with no consequence to my child except uncompleted sealants.

I certify that the above information is true and correct to the best of my knowledge. I hereby authorize Ottawa County Department of Public Health (OCDPH) to verify the information above. I understand that if I have given false information this may disqualify my child from receiving dental services. I certify that I give full consent to have my child photographed or videotaped and/or interviewed. I also give full consent for said photographs, videotapes and/or interview to be published for either health agencies use or news media releases. Records may be made available to schools, Head Start programs, dental offices clinics, health agencies, assistance programs and your health insurance plan, upon request. I have been informed that the "HIPAA Privacy Notice" is available on the county website miOttawa.org/dental. A copy of the "HIPAA Privacy Notice" is also available upon request by calling 616 494-5540.

Signature of parent or guardian	Relationship	Date

Información en español en el otro lado de esta página.