SEAL! Michigan Consent Form

School-Based Dental Sealant Program
For 2nd, 6th, and 7th grade students

miOttawa Department of Public Health
miOttawa.org/miHealth

School: _____ Grade:_____ Teacher:_____

Child's Legal Name: _____
(First) (Middle) (Last)

Address: _____ Phone #: _____
(Street) (City) (ZIP)

Date of Birth: ____ /____ /_____ Age: _____ Gender: _____ Parent / Guardian email: _____
(Month) (Day) (Year)

Child's Social Security Number: _____

Which of the following describes your child (Check One or More): ☐ Black/African American ☐ White ☐ Hispanic/Latino
☐ Asian ☐ Arab American ☐ American Indian/Alaskan ☐ Native Hawaiian/Other Pacific Islander ☐ Other

Parent Consent

(Please check one):

☐ YES ☐ NO I give my permission for my child to receive: **Fluoride, oral screening, and sealants.**

☐ YES ☐ NO I give SEAL! Michigan my permission to use photos of my child for educational or promotional purposes.

Your child's personal information will be kept private and will not be shared with any person who is not directly involved in the care of your child as part of the Health Insurance Portability and Accountability Act (HIPAA). You can find the HIPAA Privacy Notice on the website MiOttawa.org/dental. You can request a copy of the HIPAA Notice by calling 616-393-5771.

Printed parent or guardian name: _____ Date: _____

Signature of parent or guardian: _____ Relationship to child: _____

Health History

(Please check one):

☐ YES ☐ NO 1) Is your child allergic to anything? *If yes, please list:* _____

☐ YES ☐ NO 2) Does your child take any medicines? (*prescribed or not)* _____
If yes, please list: _____

☐ YES ☐ NO 3) Does your child have any medical problems like heart disease, asthma, hay fever, hepatitis, cancer, diabetes, or any other health problems? *If yes, please list:*_____
_____

☐ YES ☐ NO 4) Does your child have learning or emotional problems? *If yes,please list:* _____
_____

☐ YES ☐ NO 5) Does your child have a dentist? *If yes, what was the date of their last visit?* _____

Insurance Information

You will not be required to pay anything for this program, whether you have insurance or not. Medicaid/Healthy Kids Dental/MIChild and other dental insurance carriers could be billed to help cover the cost of this program. Please fill out insurance information.

Medicaid #: _____ and/or name of other Insurance: _____

Policy holder's name: _____
(First) (Last)

Policy holder's date of birth:_____/_____/_____ Group #: _____
(Month) (Day) (Year)

Policy or ID #: _____ *OR* Insured social security #_____

Información en español en el otro lado de esta página.