Health Department
County of La Crosse, Wisconsin
300 4th Street North, 2nd Floor
La Crosse, Wisconsin 54601-3228
Phone: (608) 785-9723 Fax: (608) 785-9846
www.lacrossecounty.org/health

La Crosse County Seal-A-Smile Parent Consent

Child's Last Name:_____ **First Name**: _____

Date of Birth: _____/_____/_____ **Teacher:**_____ **Grade:**_____

Please check one of the following:

☐ **Yes,** I give my child permission to participate in the school-based oral health program and receive any preventive treatments determined to be necessary limited to a dental screening, fluoride varnish and sealant application. I give permission for Medical Assistance to be billed for any appropriate procedures if applicable. I give the school permission to share my child's WI Student ID Number with this program. This consent is good for two years in order to apply additional fluoride varnishes and to replace possible lost sealants when checked the following school year. I have been provided with a copy of La Crosse County Health Department's Notice of Privacy Practices.

☐ **No,** I do not give permission for my child to participate in the school-based oral health program.

_____ _____ _____
Parent/Guardian (Signature) Parent/Guardian (Print) Date

If participating, please complete the following client information and questions:

Street Address:_____ **City:**_____

Primary Phone: (_____)_____ **Secondary Phone:** (_____)_____

Gender: ☐ Male ☐ Female

Race: ☐ Non-Hispanic ☐ Hispanic

Ethnicity: (*check all that apply*) ☐ African American ☐ Asian ☐ White ☐ Hispanic or Latino

☐ Native American ☐ Other (*please list*):_____

Dental Insurance: (No student will be refused services based on insurance coverage)

☐ Medical Assistance (Badger Care) ☐ Private Insurance (i.e. Delta, Cigna) ☐ No Dental Insurance

1. Does your child use medicine prescribed by a doctor? **Yes No**
2. Does your child need or use more medical care than other children the same age? **Yes No**
3. Does your child have trouble doing things most children the same age can do? **Yes No**
4. Does your child need or get special therapy, such as physical therapy, occupational therapy or speech therapy? **Yes No**
5. 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**
6. **If you selected "yes" to any of the questions above,** has this problem lasted or is expected to last at least 12 months? **Yes No**
7. Does your child have any allergies? (i.e. medications, food, latex, etc.) **Yes No**
    a. **If yes,** what type?_____
8. Does your child have a primary dentist? **Yes No**
    a. **If yes,** who is your child's primary dentist?_____When were they last seen?_____

****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.**