Aspen to Parachute
Dental Health Alliance

Garfield County

Smiles for Students Dental Program
Parent /Guardian Permission Slip

Dental Program: *Smiles for Students dental program will be coming to your school to provide 6th, 7th, and 8th grade students with* ***no cost preventive dental services.***
Registered Dental Hygienists will provide students with:

Dental Cleaning: polishing and removing dental plaque
Sealants: A protective barrier placed on molars to 'seal' out cavities
Education: Teaching students how to take care of their teeth through good brushing, flossing, and eating habits
Dental evaluation; An evaluation of the student's mouth (without x-rays)
Fluoride varnish: A protective treatment 'painted' on to teeth

I _____ give permission for my child /children named below to participate in the school dental health program. I understand that these services are meant to help prevent future dental health problems and clean my child's teeth, but will not correct dental health problems that already exist. I understand that the school dental staff may determine that my child needs further treatment. The oral health provider/health department staff will help me understand my options for treatment
I _____ give permission to photograph/video my child. Photos/videos will only be used to promote and support the school dental program.

Has your child seen a dentist within the last 12 months? ☐ Yes ☐ No
Name of Dental Provider: _____
If you provide your dentists name, a copy of dental evaluation results may be sent to your dentist.

Student Name: _____Date of Birth: _____
School: _____Grade: _____Teacher: _____
Parent/Guardian Name: _____Relationship to Child: _____
Mailing Address: _____
City: _____ Zip: _____
Contact Number: ( ) _____

Dental Insurance: ☐ Medicaid /CO Health First ☐ CHP+ ☐ Private Dental Ins. ☐ Not Insured
Ins. Identification #: _____

CO Health First/Medicaid/CHP+ will be billed for provided services. If your child does not have dental insurance they **will** still receive these dental services if this form is signed and returned. There will be no out of pocket expenses for this service.

I acknowledge receiving the Smiles for Students HIPAA notice provided with this form. Smiles for Students will treat all patient information as protected health information (PHI) under HIPPA regulations. *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.*

_____ ___/___/___
Parent / Guardian Signature *Today's Date*

Return Permission Form to:
Your Teacher or the Front Office

**Please note any medical conditions, medications, allergies, etc. that we should know about your child.

_____
_____
_____
_____