PARENTAL/LEGAL GUARDIAN CONSENT

Sealing Smiles Across NH
Traveling Tooth Fairies brings a Cavity Prevention Program to Granite State Kids

Dear Parent/ Guardian:

Traveling Tooth Fairies-Sealing Smiles Across NH (SSANH): Bringing Cavity Prevention to Nashua Kids is a cavity prevention program coming to your school during the 2024-2025 school year. Your child is eligible to participate in this program that offers the following dental services:

- oral health screening
- guided toothbrush instruction
- topical fluoride varnish
- dental sealants
- decay stopping fluoride applications, and
- temporary fillings

Note: Dental Sealants are protective coatings applied to chewing surfaces of teeth. Decay stopping fluoride (Silver Diamine Fluoride) helps stop a cavity from getting bigger. You can tell it worked if the cavity becomes hard and black over time. Dental sealants do not cause pain and do not require any shots or drilling. This cavity prevention program does not take the place of a routine dental exam. If your child does not have a regular dentist, we will recommend one to you.

Please return this form by _____ to sign up your child.

CHILD'S INFORMATION

Child's First Name:		Child's Last Name:
Child's Address:		Child's Date of Birth:
☐ Male ☐ Female ☐ Non-Binary ☐ Prefer Not to Say		
Ethnicity:	☐ Hispanic ☐ Non-Hispanic	
Race:	☐ American Indian/Alaskan Native ☐ Asian ☐ White ☐ Other, Specify:	☐ Hawaiian/Pacific Islander ☐ Black/African American ☐ Multi-race
School:	☐ Amherst Street Elementary ☐ Bicentennial Elementary ☐ Birch Hill Elementary ☐ Broad Street Elementary ☐ Charlotte Avenue Elementary ☐ Dr. Norman W Crisp Elementary ☐ Fairgrounds Elementary ☐ Fairgrounds Middle	☐ Franklin Street ☐ Ledge Elementary ☐ Main Dunstable Elementary ☐ Mccarthy Middle School ☐ Mount Pleasant Elementary ☐ New Searles Elementary ☐ Pennichuck Middle ☐ Sunset Heights Elementary
Teacher's Name:		Child's Grade:

Has your child had or do they have any serious health problems treated by a doctor? Please name:	☐ YES	☐ NO
Does your child have any allergies? Please name:	☐ YES	☐ NO
Does your child have a silver sensitivity? Please explain:	☐ YES	☐ NO
Does your child have a dentist? Dentist's Name:	☐ YES	☐ NO
Has your child seen a dentist in the last 12 months?	☐ YES	☐ NO

INSURANCE INFORMATION

Please tell us the type of dental insurance your child has:	☐ Private Insurance	☐ No insurance or self-pay	☐ NH Medicaid, please provide ID #:
NOTE: There is no fee for this service. If your child has NH Medicaid, then we will bill Medicaid.			

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PARENT OR LEGAL GUARDIAN'S INFORMATION

Parent/Guardian's First Name:		
Parent/Guardian's Last Name:		
What is the best way to reach you? Please provide your number or email:	☐ Home Phone: ☐ Cell phone:	☐ Work phone: ☐ Email:
Which concerns make it difficult for your child to get dental care? Please check all that apply:	☐ My child does not have a problem getting dental care ☐ Cost ☐ Unable to find a dentist who takes my insurance ☐ Transportation ☐ Behavioral concern ☐ Fear ☐ Difficulty taking time off from work ☐ Other, please explain:	

CONSENT FOR TREATMENT & HIPAA COMPLIANT RELEASE OF ORAL HEALTH INFORMATION

- ✓ I hereby give permission for my child to receive dental services during the 2024-2025 school year which will include an oral health screening, toothbrush guided instruction, topical fluoride varnish, and may include dental sealants, decay stopping fluoride application, and protective fillings as needed.
- ✓ I understand that not all types of cavities can be treated at school.
- ✓ I understand that any child in kindergarten through grade 12 is entitled to participate in this program. A Certified Public Health Dental Hygienist will provide treatment and an assessment of your child's teeth. A written progress report will be sent home along with a referral for any additional treatment needed for your child.
- ✓ I understand that the services provided at school cannot replace a Dental Exam by a licensed Dentist. Routine dental care is strongly encouraged.
- ✓ I have read the Notice of Privacy Practices and I understand that my child's dental assessment information gathered during their visit may be shared with NH Medicaid for billing purposes, the school nurse, the supervising dentist, and in the event of a referral, information will be shared with the dental office who will be treating your child.
- ✓ If NH Medicaid eligible and applicable, I give Traveling Tooth Fairies-SSANH program permission to bill NH Medicaid for these services.
- ✓ I have read and reviewed the Traveling Tooth Fairies - SSANH "HIPAA Notice of Privacy Practices" available at https://www.nashua.edu/
- ✓ By signing this form, I acknowledge I have read and reviewed the above.

I give permission for my child (insert name)_____ to participate in the Traveling Tooth Fairies-SSANH program offered at my child's school.

Signature: _____ Date: _____

DELTA DENTAL

NASHUA SCHOOL DISTRICT
Gateway to Opportunity

NEW HAMPSHIRE DHHS
DEPARTMENT OF HEALTH & HUMAN SERVICES