University of South Dakota
Department of Dental Hygiene
School-based Preventive Dental Program Permission Slip

The University of South Dakota Dental Hygiene Department has a School-based Preventive Dental Program and we're coming to your child's school to provide **FREE** dental screenings. We also offer dental cleanings, x-rays, fluoride varnish treatments and sealants for payment to children with their parent(s)' permission. **The program is intended to provide care for children who have not seen a dentist in the past 2 years. If you routinely see a dentist, please consult with him/her prior to scheduling with us. This appointment does not replace your routine visit with a dentist as we do not have a dentist on site.** With your permission, your child will be seen during school hours at the school in our portable dental office. You will receive information from us after your child is seen to let you know if we have any concerns about your child's teeth and to let you know what we did. Thank you for providing the following information and permission.

School _____Date_____Child's name_____Grade_____

DOB_____Age____Sex ____Ethnicity_____Parent/Guardian's name_____

Phone number_____Email address_____

Address_____City_____State_____Zip Code_____

Has your child been hospitalized in the last 3 years? [ ]Yes [ ]No Comments: _____

Are you seeing a physician at this time? [ ]Yes [ ]No If yes, give reason: _____

Is your child currently ill with a communicable disease? [ ]Yes [ ] No Comments:_____

Does your child have any allergies? [ ]Yes [ ] No List:_____

Does your child take any medications[ ]Yes [ ]No List:_____

Do you have any concerns about your child's teeth? [ ]Yes [ ]No Comments:_____

When was your child's last dental appointment?_____Dentist Name:_____

***Does your child have private dental insurance?** [ ] Yes or [ ] No **If yes, please identify cardholder's DOB**_____ and place of employment _____. **Policy number if wanting procedures billed to insurance**_____.
In addition, please provide a **copy of your dental insurance card. We will be happy to bill insurance for you.**

*If your child would like any additional services other than the free dental screening, **please make checks payable to, USD DH, and staple it to this permission slip. Checks must be attached to the permission slip or additional services will not be provided.**

*Is your child enrolled in the state Title XIX/ Medicaid or SCHIP program? [ ]Yes [ ]No If yes, ID#:_____.

I give the University of South Dakota Dental Hygiene Department permission to see my child for the following procedures **(All procedures are free for Medicaid eligible students)**:

____ **Free** Dental Screening: A visual review of the mouth to determine the health/disease status in order to refer to a dentist. **This does not include or replace a complete dental exam done by a dentist.**
____ **$20.00 per tooth** Dental Sealants: A protective coating placed on molars to prevent/slow the formation of cavities.
____ **$5** Fluoride treatment: A protective coating painted on teeth to prevent/slow the formation of cavities.
____ **$50** Dental Cleaning: Teeth cleaning and polishing.
____ **$15** Dental x-rays: Can be sent to a dentist for evaluation. Please provide Dentist Name & Location:_____
____ **$14.48 Silver Diamine Fluoride**: Decay arresting medicament—can be placed on possible areas of decay that may help slow or stop the progression of decay. THIS IS NOT A FILLING. If the tooth is demineralized or decayed, the area **WILL TURN BLACK.**

In consideration of allowing treatment, I agree to hold harmless, release, and indemnify agents, servants, and students of the University of South Dakota and its employees including, but not limited to dentists, and dental hygiene faculty, as well as agents and servants from my child's school district including, but not limited to teachers, staff, administration, and school boards, from any and all causes of action, claims, demands, or liability which may arise out of such treatment on behalf of myself, my heirs, my executors, administrators or assigns or on behalf of my minor child or children or his/her (their) heirs, executors, administrators or assigns.
I also give permission for the school to be made aware of dental referral needs for the student.

Parent/Guardian Signature:_____Date:_____

This program was made possible with funds from the HRSA Rural Health Outreach Grant Program. Please call Delta Dental Oral Health Center @ 605-658-5959, or email dh@usd.edu with any questions.