Dear Parent or Guardian,

Did you know... cavities can be prevented?

District Health Department No. 2's Community and School Oral Health Program, along with the Michigan Department of Health and Human Services offers a **FREE** grant funded program called SEAL! Michigan. To learn more about sealants, scan the QR code on this page.

SEAL! Michigan Program does not replace regular dental cleanings and exams from your child's dentist.

SILVER DIAMINE FLUORIDE (SDF): A DENTAL TREATMENT TO FIGHT CAVITIES

Dental cavities are very common in children, but Michigan Licensed Dental Providers have a safe and painless way to stop cavity progression called Silver Diamine Fluoride (SDF). SDF is a FDA-approved antibiotic liquid used to help stop tooth decay. It is simply brushed on the tooth that has decay or a cavity. For more information about SDF scan the QR code on this page.

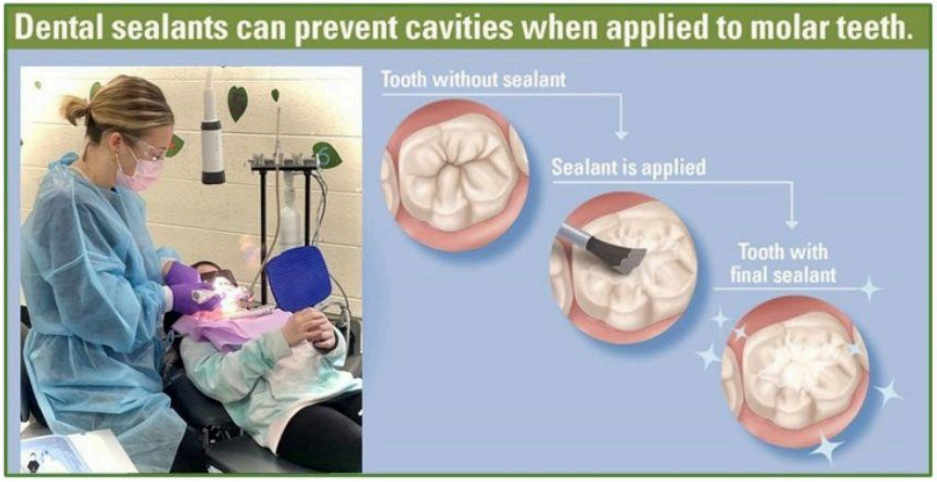
About SDF Applications

- Applied only on back teeth
- Black or brown stain on the affected area is normal, this means SDF is working
- Healthy parts of the tooth will not be stained
- Does not replace the need for follow up care at your general dentist, a referral will be made
- Gums or cheeks could be stained - this is harmless and will go away in 1-4 weeks
- Could cause temporary metallic taste

Elisa Dack, RDH, MHSA
Community Health Director/Oral Health Coordinator
989-329-4341
edack@dhd2.org

SEAL!
MICHIGAN

District Health Department No. 2
www.dhd2.org



PLEASE RETURN THIS FORM TO SCHOOL OFFICE BY:

(Put date in)

Please complete the first section of this form, even if you decline services, so we can count your response.

THANK YOU!

We can assist you with applying for medicaid, medical insurance, or dental insurance if needed.

Please call us at 1-800-504-2650

www.dhd2.org

www.dentalclinicoffice.org

SEALANT FACTS

SDF FACTS

FREE SCHOOL-BASED DENTAL SEALANT PROGRAM

Consent covers oral health assessment, sealants, fluoride treatments and retention check for sealants. All services provided by a Registered Dental Hygienist.

Register Now! All returned forms are eligible for prizes!

District Health Department No. 2
www.dhd2.org

About Your Child

School:_____ Grade: _____ Teacher: _____

Child's Legal Name: _____

Address: _____ Phone #: _____

Date of Birth: ____/ ____/ _____ Age: _____ Male or Female Cell Phone #: _____

Preferred Language (Check one): ☐ English ☐ Spanish ☐ Other (Please specify): _____

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

☐ **YES, to all oral health services!**

☐ **YES**, I give my permission for my child to receive: Oral health assessment, sealants, fluoride varnish **(NO SDF)**

☐ **YES**, I give my permission for my child to receive: Oral health assessment and sealants only. **(NO SDF or varnish)**

NO, I do not give my permission for my child to receive treatment with District Health Department No. 2

Printed Parent Name: _____ Date: _____

Signed Parent Name: _____

This consent will be valid for the 12-month period of this program.

DHD2 Community and School Oral Health Program and SEAL! MI have permission to take/use photos of my child for educational and promotional purposes, and to share with my child's school.

☐ YES to photos!

☐ NO to photos.

Health History

(Please circle)

YES / NO 1) Is your child allergic to anything? If yes, what? _____

YES / NO 2) Is your child taking any medications? If yes, what? _____

YES / NO 3) Does your child have any medical conditions such as heart disease, asthma, hayfever, hepatitis, cancer, diabetes, any artificial joints, or other medical conditions? If yes, what? _____

YES / NO 4) Does your child have learning or emotional impairments? If yes, what?_____

YES / NO 5) Does your child take a pre-medication for dental procedures? If yes, what? _____

Insurance Information

*****We will send a report to your child's dentist as a follow-up. Please provide the dentist or clinic name:** _____

No payment is required from you for this program. However, Medicaid/Healthy Kids Dental/MI Child and other dental insurance carriers will be billed to help cover the cost of this program. Please fill out the insurance information.

Medicaid #_____ Name of Insurance _____

Insured Name _____ Date of Birth _____/_____/_____

Policy ID # _____ Group # _____

Employer _____ Insurance Phone # _____