●Dental Screenings ●Dental Sealants

●Fluoride Varnish

●Oral Health Education

These services are at NO COST to all:
2nd- 8th Grade Students

I-Smile @ School helps prevent tooth decay and keeps smiles healthy!

Ask your child's teacher or your school's health associate how to sign up or complete and return the registration found on Peach Jar to your child's classroom.

You may Contact the I-Smile @ School coordinator Liz Addison for more information at:
712-256-9566 ext.220 laddison@familyia.org

Family Inc. Consent and Release of Information – PNP

Child's Name:		Age:	Date of Birth:
Address:		Cell Phone: Other Phone:	

☐ Male ☐ Female	Race:	☐ White ☐ Black	☐ Hispanic ☐ Asian/Pacific Islander	☐ Native American ☐ Other

School:	Teacher's Name:	Grade:

Child's Physician:		Child's Dentist:	
If applicable, child's Medicaid ID Number:		Email address:	

☐ **YES**, I give permission for my child to receive a dental screening, dental sealants and fluoride varnish application. (Please fill in the entire form, read and sign both places below)

Please answer the following questions:

1. Is your child currently under a physician's care? ☐ Yes ☐ No
2. Is your child currently taking any medications? ☐ Yes ☐ No
3. Does your child have any allergies? ☐ Yes ☐ No

Please explain any YES answers: ______________________________

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☐ **NO**, I do not give permission for my child to receive a dental screening, dental sealants and fluoride varnish application. (Please fill in name and sign below)

Please answer the following questions:

1. Does your child have a regular dentist? ☐ Yes ☐ No
2. If yes, does your child see that dentist at least once a year? ☐ Yes ☐ No
3. Is your child eligible for the free/reduced lunch program at school? ☐ Yes ☐ No
4. My child's most recent dentist visit was within the past: (please check **one**)

☐ 6 months ☐ 1 year ☐ 3 years ☐ 5 years ☐ Has never seen a dentist

5. How do you pay for your child's dental care? (please check **one**)

☐ Self ☐ Medicaid/Title XIX ☐ *hawk-i* ☐ Private dental insurance ☐ Other

6. List any concerns you have about your child's mouth or teeth: ______________________________

I consent to the agency's use of email and texting to send me scheduling and child health services information.
☐ Yes ☐ No

- I was offered a Notice of Privacy Practices.
- I understand that this consent is valid for one (1) year unless withdrawn in writing by parent or guardian.
- I understand that the services that will be received do not take the place of regular dental checkups at a dental office.
- I understand that these services are provided under the Iowa Department of Public Health, Maternal and Child Health Program.
- I understand records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health, Iowa Medicaid Enterprise, or designee for audit and quality improvement purposes or other legally authorized purposes.

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Parent / Guardian Signature **Date**

I voluntarily authorize Family Inc. to release, obtain, or exchange information with the following: Family Inc. staff, school staff, physicians, dentists, Head Start Centers. This release does *not* authorize disclosure of material protected by federal and/or state law applicable to substance abuse, mental health, and/or AIDS-related information.

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Parent / Guardian Signature **Date**