PLEASE RETURN APPLICATION TO SCHOOL BY:
SEPTEMBER 29, 2023

JUST KIDS DENTAL

2023-2024 Wisconsin School-Based Dental Program Application

Did you know an oral health program is available at your child's school?

- Just Kids Dental (JKD) has partnered with your school district at no charge to provide school-based dental services to uninsured and underinsured children at school.
- JKD has a team of dedicated Registered Dental Hygienists who provide compassionate care on-site at school utilizing portable dental equipment.

Who do we serve?

- Children in households participating in FoodShare (SNAP), W-2 Cash Benefits (TANF), or Food Distribution Program on Indian Reservations (FDPIR), children enrolled in Medicaid/BadgerCare/ForwardHealth or Head Start and foster, homeless, migrant, and runaway children.

What dental services are provided by a Registered Dental Hygienist?

- Oral Hygiene Instruction
- Oral Health Screening
- Dental Cleaning
- Fluoride Varnish
- Sealants
- Oral Health Kit which includes toothbrush, toothpaste, and floss

AN APPLICATION MUST BE COMPLETED IN INK AND RETURNED TO SCHOOL BEFORE YOUR CHILD MAY RECEIVE SERVICES.
COMPLETE A SEPARATE APPLICATION FOR EACH CHILD.
ALL QUESTIONS MUST BE ANSWERED FOR YOUR CHILD TO RECEIVE SERVICES.

IF YOU DECLINE SERVICES FOR YOUR CHILD
PLEASE DO NOT RETURN FORM AND STOP HERE

School Name: _____

Child's Teacher: _____ **Child's Grade:** _____

Child's FIRST Name: _____ **MIDDLE:** _____ **LAST Name:** _____

Male: _____ **Female:** _____ **Child's Date of Birth:** _____/_____/_____ **Age:** _____ **Daytime Phone:** (____) _____-_____

Address: _____
Street **City** **State** **Zip Code**

Ethnicity: _____ Hispanic _____ Non-Hispanic **Race (select all that apply):** _____ American Indian/Alaska Native _____ Asian _____ Black/African American _____ Native Hawaiian/Pacific Islander _____White

EMERGENCY CONTACT INFORMATION

CONTACT NAME: _____

CONTACT PHONE NUMBER: (_____) _____-_____

RELATIONSHIP TO CHILD: _____

COMPLETE BACK SIDE OF FORM!

HEALTH HISTORY (CHECK YES OR NO)

YES / NO **Is your child allergic to anything? (i.e., medications, food, latex, etc.) If YES, list:** _____

YES / NO **Does your child use medicine prescribed by a doctor? If YES, list:** _____

YES / NO **Does your child have any diseases or special health care needs? If YES, list:** _____

YES / NO **Has your child ever seen a dentist?**

YES / NO **Has your child had a dental cleaning in the last 6 months? If YES, name of dentist and date of visit?** _____

Does your household participate in any of the following? (CHECK ALL THAT APPLY)

- ○ FoodShare (SNAP)
- ○ W-2 Cash Benefits (TANF)
- ○ Food Distribution Program on Indian Reservations (FDPIR)

Is your child enrolled in any of the following? (CHECK ALL THAT APPLY)

- ○ Medicaid/BadgerCare/ForwardHealth
- ○ Head Start

Is your child? (CHECK ALL THAT APPLY)

- ○ Foster
- ○ Homeless
- ○ Migrant
- ○ Runaway

INSURANCE INFORMATION (CHECK THE APPROPRIATE BOX)

☐ **1. My child is covered by Medicaid/BadgerCare/ForwardHealth.**

ForwardHealth
Wisconsin serving you

Write your child's 10 DIGIT Medicaid/BadgerCare/ForwardHealth ID # here: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ **2. My child is covered by private insurance (i.e., Delta, Cigna, Humana).**

☐ **3. My child has no insurance.**

REQUIRED INFORMATION FOR WISCONSIN SEAL-A-SMILE PROGRAM FUNDING

DOES YOUR CHILD (CIRCLE YES OR NO)

1. **YES / NO** Need or use more medical care than other children the same age?
2. **YES / NO** Have trouble doing things most children the same age can do?
3. **YES / NO** Need or receive special therapy, such as physical therapy, occupational therapy, or speech therapy?
4. **YES / NO** Need counseling or treatment for behavior or emotional problems or delays in walking, talking or activities other children the same age can do?

IF YOU CIRCLED YES TO ANY OF THE QUESTIONS ABOVE:

5. **YES / NO** Has this lasted or is expected to last at least 12 months?

- I give my child (or am the rightful legal guardian of this child) permission to participate in the school-based oral health program and receive any preventive treatments determined to be necessary limited to a dental exam/screening, fluoride treatments and application of sealants. In addition, I give permission to bill my insurance for any appropriate procedures (when applicable). This consent is good for 12 months from the date in which is signed. I have the ability to unenroll from this program at any time by providing written withdrawal of consent.
- The treatment which your child will receive in this program is not meant to be an alternative to regular dental care. It is still strongly recommended that you seek out a dental home (family dentist) for routine dental care including any follow-up care which may be recommended after your child has completed this school-based oral health program.
- I consent to pictures of my child to be taken and possibly used in newspapers, web or for promotional use of JKD. Please print NO if you do not consent to photo portion of form: _____

CONSENT TO TREATMENT

By signing below as legal guardian of the above-named child I consent to my child participating in the school-based dental program.

Name of legal guardian (PLEASE PRINT): _____

Signature of legal guardian: _____ **Relationship to Child:** _____ **Today's Date:** _____ / _____ / _____