FT BELKNAP IHS SCHOOL DENTAL PROGRAM

Harlem Public Schools values student health and recognizes that healthy children learn best. There are times during school when student have the opportunity to participate in health screening activities. Throughout the school year, staff from the Agency and Hays dental clinics will be providing **dental screening exams**, applying **fluoride varnish, sealants** and providing **temporary fillings** as needed.

EXAM: This is a visual exam and does not include x-rays. Children with dental needs are referred to the dental clinic at the Agency or Hays for complete exams, treatment or referrals.

FLOURIDE VARNISH: Our goal is to apply fluoride varnish to the children's teeth about every 3 months. This has been shown to prevent and slow down dental decay dramatically. It is applied with a brush and is pleasantly flavored.

SEALANTS: A hard plastic coating is placed on the biting surfaces of the teeth to prevent food and bacteria from getting in the small grooves where decay begins. Teeth that have sealants have a much better chance of not getting decay.

TEMPORARY RESTORATIONS: When there is a large amount of decay in a tooth a fluoride containing temporary restoration can be placed at the school. It is pink in color and is meant only to get the tooth by until the child can be seen at the clinic. **IT IS NOT CONSIDERED A PERMANENT RESTORATION AND FOLLOW-UP AT THE DENTAL CLINIC IS CRITICAL TO SAVING THE TOOTH!**

CHILD'S NAME:_____GRADE:_____

I CONSENT for my child to participate in the school dental program as described above:

_____ _____

Parent or Legal Guardian Date

I DO NOT wish for my child to participate in the program:

_____ _____

Parent or Legal Guardian Date

IF YOU <u>WANT</u> YOUR CHILD TO BE A PART OF THE CHILD HEALTH MEASURES PROJECT, SIGN AND RETURN THIS FORM TO YOUR CHILD'S SCHOOL BY Date:

_____Month _____Day _____Year

I **<u>WANT</u>** MY CHILD TO PARTICIPATE IN THE CHILD HEALTH MEASURE PROJECT.

Please print in the space provided below:

Child's Name: _____

Parent's Name: _____

Child's School: _____

Child's Grade: _____

<u>Tribal Optional Stations (Please Check all that apply):</u>

____Tribal Blood Glucose Testing

____Tribal Body Composition Measurement

____Tribal Immunization Status Check and Referrals

Each year, you will be notified of your child's measurement status via a "Child Health Measurement Report Card." If the measurement screening identifies your child with potential abnormal measures, you will also be notified via a letter to encourage you to follow up with a health care provider.

Name of Parent or Guardian: _____

Address of Parent of Guardian: _____

_____

_____

Phone: _____ E-mail:_____

Signature of Parent of Legal Guardian:_____

Date:_____