Dear Parent or Guardian:

Your child may be eligible to participate in a Dental Hygiene Program at school. If your child is not currently established with a dentist they may be seen by a Registered Maine Dental Hygienist. This program is held during school hours. Please return signed permission slip and brief medical history to participate.

We provide ***cleanings, sealants, oral inspections, oral hygiene instructions and temporary fillings***. A report will be sent home with your child concerning our findings.

This ***Confidential*** program is provided to children who have current Maine **Care** numbers, ages 20 and under. Others without Maine Care may self pay on the day of service. Cleaning and fluoride treatment ages 12 and under is $42. Cleaning and fluoride ages 13 to 20 is $52.

Patients in the program will be seen for about 30 minutes, one to two times a year to receive this care. Only individuals with a *completed* and *signed permission slip* will be seen; **if there are medical changes this school year, please notify us and the school nurse!!**

If you would like your child to participate in this program, please complete the form at the bottom of the page and return it to your school. You may call **SMILE PATROL** at 717-8272 or SMILEPATROL@hotmail.com with questions or if you wish to self pay on day of service.

School Name _____ Grade_____ Male or Female
Child's Name_____
Maine Care #_____ Date of Birth - -
(No other insurance accepted)(If you have other insurance than MC, you must self pay)

Address_____Town_____Zip code_____
Phone Number:_____ cell:_____work:_____
Current Medication or Medical concerns:_____
Allergies_____
Has your child taken an antibiotic before dental treatment in the past? _____
Heart Condition _____Heart murmurs_____ mitral valve prolapse _____
Physician's Name: _____
My child currently sees a dentist or hygienist? (Y) (N) **Date** of last visit__----__ **Location:** _____
Name of dentist: _____
Services received at last visit (circle) cleaning, fluoride, sealants, temporary filling other. Do you have any dental concerns? _____

Yes, I give permission for my child to receive the dental preventive services listed above. I understand that services provided do not take the place of an exam by a dentist. I understand Smile Patrol is HIPPA compliant, all records are kept confidential and all insurance claims will go directly through Smile Patrol per electronic transfer. **I agree to notify the school nurse of any changes to my child's Medical History.**

Please sign here _____Date_____

Please print your name_____