



Project Saving Smiles

8000 North Stadium Drive #26 Houston, TX 77054-1823 832-395-0054

HOUSTON HEALTH
DEPARTMENT

STUDENT INVITATION TO PROJECT SAVING SMILES

No Cost Dental Screening, Sealants, Fluoride Varnish, and Oral Health
Education for Middle School and High School

Attention Parent/Legal Guardian!

Your child's teeth are important and can last a lifetime. Keeping your child's teeth clean is very important in preventing cavities, bad breath, and tooth loss due to cavities. Teeth allow us to chew healthy and crunchy vegetables and fruits. Children do well in school when they do not have problems with their teeth. Healthy teeth make for picture-perfect smiles!

Your child's school has been selected to participate in **Project Saving Smiles (PSS)**. This project provides **Dental Screening, Sealants, Fluoride Varnish, and Oral Health Education at no cost** for Middle School and High School age students. The Houston Health Department (HHD) and its partners will carry out this project. After the screening, a written report will be provided for your child to take home.

Fluoride varnish is a protective coating painted on the teeth to help prevent new cavities and to stop cavities that have already started. Dental sealants are thin coatings applied to the chewing surface of the back teeth to prevent cavities. Sealants fill in the deep pits and grooves where food and plaque (bacteria) accumulate. Sealants, in time, may need to be reapplied to remain protective to the teeth. Your child's sealants may be checked after one year to make sure they are still on the teeth. If needed, new sealants will be placed, and another application of fluoride varnish will be applied. No shots or anesthesia is needed for the application.

Only students with a completed and signed parental consent form will be eligible to participate in the project. If you have any questions or concerns, please contact your child's school nurse.

The HHD and its PSS partners look forward to serving your child as we work together to improve the oral health of Houston's children.

Parent/Guardian Must Complete the HISD Transportation Consent Below



HOUSTON INDEPENDENT SCHOOL DISTRICT Transportation Consent

I hereby consent to allow my child, _____, to be bused to the
Child's Name

West End Health Center (190 Heights Blvd, Houston, TX 77007) on a field trip to the Project Saving Smiles clinic. The field trip will be accompanied by teachers/sponsors between the hours of 8:00am and 2:00pm. This is to certify that the child named on this consent has your permission to go on the field trip to the Project Saving Smiles event at the West End Health Center. In case of an emergency, you will be contacted at the phone number you provide below.

☐ I Do ☐ I Do Not give consent for my child to participate in Project Saving Smiles.

Parent/Guardian Signature

Phone Number

Date

Please read, complete, and sign the consent form and return to your child's school nurse.



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SCHOOL: _____

PARENTAL CONSENT FORM

No Cost Dental Screenings, Sealants, Fluoride Varnish, and Oral Health Education

Complete the information below in **black or blue ink only** and sign the General Consent Statement for your child to participate.

STUDENT'S NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	AGE	DATE OF BIRTH (MM/DD/YYYY)
ADDRESS	APT. #	ZIP CODE	TELEPHONE NUMBER	
PARENT/LEGAL GUARDIAN NAME		TEACHER		

Child's Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ American Indian or Alaska Native ☐ Other

Please complete the insurance information below (Please Detail). **Your child will still receive services if not insured, at no cost to you.**

☐ Medicaid (DQ/MCNA) ☐ Private Insurance ☐ CHIP ☐ No Insurance ☐ WIC

Is your child, or a member of your family, enrolled in WIC? ☐ Yes ☐ No

My child is allergic to: ☐ NONE ☐ Allergies: _____

My child is taking (list medications): ☐ NONE ☐ Medications: _____

My child has the following medical problem(s): ☐ NONE ☐ Heart surgery or murmur ☐ Asthma ☐ Epilepsy ☐ Diabetes

☐ Other (please describe) _____

☐ Behavioral considerations (please describe) _____

Number of Members in Household: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 or more

Annual Income of Household: ☐ \$0 - \$23,000 ☐ \$23,001 - \$32,000 ☐ \$32,001 - \$40,000 ☐ \$40,001 - \$48,000
☐ \$48,001 - \$56,000 ☐ \$56,001 - \$64,000 ☐ \$64,001 - \$72,000 ☐ \$72,001 - \$80,000 ☐ >\$80,000

I agree to have my child or my child's teeth photographed for educational and/or promotional purposes. ☐ Yes ☐ No

If we need to contact you by phone or note, what is your preferred language? ☐ English ☐ Spanish ☐ Other: _____

General Consent Statement

I understand an informed consent is required before the services can be provided. I hereby give permission for my child to receive a **no cost** dental screening, fluoride varnish and, if eligible, preventive dental sealants. I understand an allergic reaction may occur if my child is allergic to latex or to dental materials used to screen, to place dental sealants, and to apply fluoride varnish. I understand these dental services are performed as preventive measures and do not eliminate the need for routine dental examination and periodic x-rays by a dentist. Since I am not accompanying my child to the screening, I authorize the school nurse or an appropriate school representative as the accompanying adult for this activity. I give consent for anonymous information obtained from this program to be used to gain insight into the oral health of the community, and access to academic and attendance information. I understand my child's sealants may be checked within two years to make sure they are still there. If needed, new sealants will be placed free of charge and another application of fluoride varnish will be applied. **I authorize my insurance benefits to be paid directly to the medical provider and authorize the medical provider or Insurance Company to release any information required for this claim.** Additionally, I understand I am free to withdraw my consent to the above dental services at any time by submitting written notification to the school nurse. Otherwise, this consent will remain in effect for two years from date of signature.

Parent/Legal Guardian Signature _____ Date _____

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the City of Houston collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the city agency to correct any information that is determined to be incorrect. For further information, contact Ms. Carol Smith, Privacy Officer, Houston Health Department at Carol.Smith@houston.tx.gov.