ForsythKids School Oral Health Program helps keep children healthy by bringing dental prevention right to their school. Keeping your child’s mouth healthy is our goal. The ForsythKids program includes:

- Dental Exam: two times a year
- Teeth Cleaning: two times a year
- Fluoride Treatments: three times a year to prevent cavities
- Dental Sealants: as needed to protect chewing surfaces of permanent (adult) teeth
- Health Education: at each visit to remind children how to care for their teeth at home
- Toothbrush and Toothpaste: two times a year
- Sedative Fillings: as needed to stop decay until a child can visit the dental office
- Take-Home Form: at each visit with information about your child’s needs and care provided
- Follow-Up Assistance: as needed if follow-up care is required
- Help Locating a Dentist: if you need to find a dental office in your community.

Things to Know about ForsythKids:

Services: ForsythKids provides care that helps prevent cavities and gum disease, especially for children who do not see a dentist every year. **Children who see a dentist regularly may not need ForsythKids care at school.** ForsythKids services do not replace a visit to the dental office.

Participation: Any child may participate in ForsythKids. Even if your family has no dental insurance, you are welcome to enroll your child in the program at no cost to your family. If your child is covered by MassHealth or private dental insurance, we will bill for services provided but there is no co-pay, fee or charge to your family. You may withdraw your child from the program at any time. Please withdraw in writing to school nurse or via email to forsythkids@forsyth.org Enrollment is voluntary, and your child is not required to participate.

ForsythKids Staff: ForsythKids is staffed by licensed dentists, licensed dental hygienists and certified dental assistants. ForsythKids also employs patient advocates to help you find a dentist in your community if your child needs follow-up care.

Patient Information: ForsythKids privacy policy is enclosed. This Notice of Privacy Practices follows federal and state guidelines for protecting patient information. As part of the program, your child’s dental information will be shared with the school nurse or other designated school officials. You will receive a written report of the dental services provided following each ForsythKids visit. You may request a copy of your child’s ForsythKids dental records at any time by contacting the program staff listed below.

Questions: If you have questions about ForsythKids, please contact the Patient Advocate in your area:
Kathy Eklund     keklund@forsyth.org     (617) 851-2920     Cape Cod
Pilar Creech     pcreech@forsyth.org     (617) 851-5351     Lynn and/or en español
Ramon Baez       rbaez@forsyth.org      (617) 892-8377     Boston/Hull/Randolph

Next Steps: To enroll your child in ForsythKids, check YES on the back page, complete the consent form and return it to the school within one week. Thank you!

Please turn over →
ForsythKids School Oral Health Program Consent Form

Do you want your child to receive dental care from ForsythKids?

☐ YES: Please print information, sign, date & return to your child’s teacher or the school nurse

Child's Name ________________________________ (first) ________________________________ (last)

Male ☐ Female ☐ Date of Birth: __/__/______ Child's Primary Language: ____________________________

School: ___________________________ Grade: ______ Room: _______ Teacher: ________________

Parent/Guardian's Name: ___________________________ Parent/Guardian's Primary Language: __________

Parent/Guardian's Address: ___________________________ Apt. #: __________ City: __________ State: ______ Zip: _______

Parent/Guardian's Phone #: Home (_______) _______ - _______ Cell (_______) _______ - _______

Email: ____________________________

Dental Information:

☐ My Date of last dental check-up: _______/______/______

☐ My child's only dentist is the ForsythKids. ☐ NO ☐ YES ☐

☐ My child has a local dentist. ☐ NO ☐ YES ☐ Dentist name: ____________________________

☐ I would like help finding a local dentist. ☐ NO ☐ YES ☐

My child needs to take antibiotics before having dental treatment. ☐ NO ☐ YES ☐ Why?: __________________________

Please tell us about your child's dental experiences: ______________________________________________

Have you (Parent/Guardian) ever had a toothache? ☐ NO ☐ YES ☐

Medical Information:

☐ My child's Medical Doctor or PCP is: ____________________________ Phone #: (_______) _______ - _______

☐ My child has a serious medical condition: ☐ NO ☐ YES ☐ Please (✓) all that applies

☐ Asthma ☐ Seizures/Epilepsy ☐ Kidney/Liver Disease ☐ Immunologic Disorders ☐

☐ Blood Disorders ☐ Tuberculosis ☐ Diabetes ☐ Cancer ☐ Disabilities/Special Needs ☐ ADD/ADHD ☐ Autism ☐

If checked please explain: __________________________________________________________

☐ My child is taking medication. ☐ NO ☐ YES ☐ Name of medication: ____________________________

☐ My child is allergic to: Penicillin ☐ Antibiotics ☐ Latex ☐ Foods ☐ Nuts/Tree Nuts ☐ Dyes ☐ Other ☐

Other Information:

Child's race: ☐ Black/African American ☐ White ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐

☐ More than one race ☐ I do not wish to answer ☐

Hispanic origin: ☐ YES ☐ I do not wish to answer ☐

Housing: ☐ Own ☐ Rent ☐ Transitional (e.g.: YMCA, Hotel, Shelter) ☐ I do not wish to answer ☐

I give permission for photos or videos to be taken of my child during a ForsythKids school visit. ☐ NO ☐ YES ☐

Insurance Information:

These services are provided to all children who wish to participate even if you do not have dental insurance.

My child has the following Dental Insurance that ForsythKids may bill for dental services provided to my child:

MassHealth ☐ MassHealth RID Number: __________________________

Other Dental Insurance ☐ Name: __________________________

Group Policy #: __________________________

Individual Policy #: __________________________

Address of Insurance Company: __________________________

Subscriber Name: __________________________ Subscriber ID: __________________________

Employer Name: __________________________ Subscriber D.O.B.: __/__/______

I agree that the above information is correct and have read the program description on the opposite page. I understand that my son/daughter can receive care using this signed consent form for the duration of my child's enrollment in the school. I understand I may withdraw this consent form in writing to the school nurse or by email to forsythkids@forsyth.org at any time during my child's enrollment in the school.

SIGN HERE Parent/Guardian: __________________________ Date: __/__/______

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