Environmental Scan:
Parental Consent Form Return Rates and Best Practices

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Oral Health America changes lives by connecting communities with resources to increase access to care, education, and advocacy for all Americans, especially those most vulnerable.

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Barriers to Obtaining Parental Consent

Summary of Project

- The Task Force on Community Prevention Services issued a strong endorsement for the implementation of school-based sealant programs.
- Dental sealants are safe and nearly 100% effective in preventing cavities on the chewing surfaces of the tooth.
- Services are provided free of charge in a school-based or school-linked setting.
- Nearly one in every five children in the United States suffers from untreated cavities.
- An estimated 17 million American children go without dental care every year.
- Most school-based programs average only a 50-60% return rate of parental consent forms.

School-based programs are working to resolve the crisis... So why is participation low?

Understanding and Prioritizing Oral Health
- American public tends to lack an adequate understanding of the importance of good oral health.
- Parents are often unfamiliar with dental services offered by programs.

Socioeconomic Factors
- Race & poverty level identified as significant factors in predicting likelihood of childhood caries.
- Distrust in programs targeted toward low-income populations.

Children As Information Carriers
- Information often gets misplaced or ignored in backpacks.
- Older children are more likely to throw away, lose, or hide forms.

School Sponsorship
- School staff members may view the program as an intrusion of their time.
- Unsustainability of programs backed primarily by one influential individual in the school.

Communication
- Mutual uncertainty: longstanding issues of poor communication between schools and parents.
- Non-native English speaking parents fear miscommunication with dental professionals.

An Interprofessional Dialogue: Promising Practices for Improving Parental Consent Form Return Rates

WHO?
- School Administrators provide infrastructure and resources, help to improve "community buy-in."
- School Nurses are adept at following up with parents and identifying students at highest risk.

WHAT?
- Incentives: Tangible/Intangible, Individual/Classroom-based.
- Reminders: Audible & Visible.
- Forms: Accessible content & "Eye-catching" appearance.

WHEN?
- Distribute forms with other school paperwork at the start of the academic year.
- Often takes up to 4 weeks to achieve successful return rate.
- Mid-point follow up and form redistribution.

WHERE?
- Make forms available at back-to-school fairs & open houses.
- In-school oral health education presentations.
- Post information on school website, lunch menus, calendars, and newsletters.
STATEMENT OF NEED

Nearly one in every five children in the United States suffers from untreated cavities, making dental caries the most common chronic childhood illness in our country. Despite this staggering figure, however, there is enormous potential for improvement: tooth decay in school-aged children can be almost entirely eliminated with the combination of dental sealants and fluoride available today. Still, an estimated 17 million children in our country go without dental care every year. Even more disturbing, this demographic is disproportionately comprised of children from certain racial/ethnic groups and those living in poverty; according to the Centers for Disease Control and Prevention, both race and poverty level are significant factors in predicting the likelihood that a child will experience untreated dental caries. This oral health crisis has claimed the attention of dentists, public health officials, and school staff alike, and it is clear that the systematic problem demands an interprofessional dialogue.

Operating sealant programs in school settings presents a community-based approach to preventing oral disease among underserved populations. The first school-based and school-linked dental sealant programs were reportedly introduced in the 1970s, but became common in the 1980s after the National Preventive Dentistry Demonstration Program reported their effectiveness. When the Task Force on Community Prevention Services (2002) identified school-based sealant programs as an effective system for reducing tooth decay in children, it issued a strong endorsement for the implementation of school-based sealant programs. Dental sealants are safe, and are nearly 100% successful in preventing cavities on the chewing surface of the tooth. Moreover, when treatment is offered free-of-charge in schools, otherwise inaccessible care is made available for all students, regardless of socioeconomic background; the impact of this development is staggering given the unfortunate reality that the financial burden is a chief obstacle preventing underserved populations from making regular visits to the dentist’s office. Thus, by critical review, the school-based model offers an ideal approach for improving the oral health of our nation’s children.

Despite the vast potential of the school-based system, however, a discouraging trend has been observed across so many functioning programs: low return rates of parental consent forms. In fact, an evaluation conducted by the Children’s Dental Health Initiative found that failure to obtain signed parental consent was the primary barrier challenging the mission to seal more children’s teeth. This anomaly ultimately means fewer sealant applications are performed, and countless children eligible to receive preventative treatment free-of-charge are left unnecessarily susceptible to oral disease. Given the proven benefits and unique accessibility of these interventions, it seems counterintuitive that communities would deny this opportunity for preventive treatment. Still, the research suggests that a staggering proportion of children
eligible for programs are not taking advantage of the programs; most school-based programs average only a 50-60% consent return rate for students eligible for the program. When most programs are only able to see about half of the children qualified to receive care, the remainder are left untreated and vulnerable.

Even more upsetting is the realization that, as is true when considering any average, many programs fall below this 50-60% return rate. An archetypal case can be seen in the CHRISTUS School Based Health Centers Dental Caravan program, a Smiles Across America™ program partner. During the 2013-2014 school year, CHRISTUS planned to serve 2,200 children via their Dental Caravan program, hoping to achieve parental consent form return rates of 80%. Program coordinators were aware by the mid year point, however, that these projections would not be met: “in spite of Dental Caravan’s staff’s presence in the school to distribute consents and conduct class to class oral health presentations, the status of the consent returned so far will not meet projected numbers”8. Unfortunately, this anticipation proved correct. The program received only 1,377 consent forms of the 3,709 distributed, for a return rate of just 37%. Even more, 98% of children who returned consent forms were served, with school absences and transfers accounting for the few exceptions9. Therefore, the CHRISTUS Dental Caravan program was rendered unable to fully serve all of the children it could have and would have served due to poor consent form return rates. Sadly, this is not an exceptional case; the tribulations of this single program are representative of countless school-based dental care programs across the country.

Obtaining signed parental consent forms is a significant barrier to many school-based initiatives across various professions, including both the health and social sciences. Given the broad need to achieve higher return rates, it is in the best interest of all stakeholders to collaborate in efforts to repair the fragmented system. At this point, progress has been made to the extent that poor return rates have at least received recognition as a pervasive problem; moreover, multiple studies and publications have been dedicated to the issue. While it is difficult to isolate any one incentive or procedure as yielding a higher percentage of returned forms10, several common themes emerge in an examination of best practice reports. Ultimately, it will valuable to identify and synthesize these results into a comprehensive approach for improving return rates. This report will first address the critical issues that confront efforts to collect returned consent forms, and will then attempt to integrate various techniques in proposing a best practices model.
ISSUE I: UNDERSTANDING AND PRIORITIZING ORAL HEALTH

Despite the extensive national dialogue devoted to healthcare, the American public lacks an adequate understanding of the importance of oral health. Many dentists attribute prevalent tooth decay among young children to parents' incomplete knowledge of proper oral hygiene practices. This situation presents a fundamental challenge to children's oral health programs: not only are program representatives challenged to make contact with parents, but they are also pressed to convince this audience that their children's oral health demands urgent attention as a priority item. This is no menial task, given that most parents are unfamiliar with the dental procedures offered. Furthermore, without a substantive knowledge of preventive dental measures, many parents are unsurprisingly skeptical of the treatments. This translates into considerable implications for school-based oral health programs, as parents are hesitant to sign consent forms for programs they don't completely understand; in fact, parent focus groups cited this sentiment of uncertainty as a key factor contributing to their reluctance to return consent forms.

ISSUE II: SOCIOECONOMIC FACTORS

Undeniable relationships have been recognized connecting oral health disparities to certain socioeconomic factors. Specifically, members of low-income families and some racial and ethnic minority groups are disproportionately affected by oral health problems; and within these backgrounds, children are a particularly vulnerable subgroup. A general acknowledgment of this inequality has claimed the focus of many school-based programs, as they direct their services toward these target populations. Still, this seemingly simple, supply-and-demand paradigm is complicated by the highly nuanced upshots of socioeconomic discrepancies in our country.

It is difficult to readily and accurately translate the technical language of healthcare into a vernacular more approachable for a general audience. If this issue of reading about unfamiliar concepts and procedures already presents an undertaking for the common American family, the task only becomes more difficult for non-English speakers when such topics are communicated in English only. For these parents who are less comfortable, or perhaps altogether foreign to the English language, this barrier may create a sense of distrust and hesitation about the program. In its Evaluation of School-Based Dental Programs, the Center for Oral Health cited communication issues as a main factor contributing to cultural distrust among Latino parents in regarding American dental professionals; according to the report, Spanish-speaking parents expressed concern that miscommunication could endanger the health of their children, and this anxiety prevented them from signing consent forms. This sentiment is
particularly worrying in light of the fact that Latino children have worse oral health than children of any other racial or ethnic group in the country\textsuperscript{13}.

Yet even when parents comprehend the information provided by program representatives, socioeconomic conceptions may render them less receptive to free dental care opportunities for their children. In some cases, low-income families have become accustomed to having limited choices with respect to healthcare, and thus approach free offers with caution; intuition tells them to be distrustful of programs that are free and apparently directed toward low-income populations. A common worry regarding this sort of program is that the services will not be delivered professionally, and some parents even express concern that the healthcare providers might be students using their children for training\textsuperscript{6}. Oftentimes, these parents reject care of any kind\textsuperscript{6}. Given these concerns, it is unsurprising that many parents ultimately decide to reject services altogether.

\textbf{ISSUE III: CHILDREN AS INFORMATION CARRIERS}

Realistically, children are not the most reliable messengers for relaying important information. Certainly this issue is not specific to school-based oral health programs, and confronts a wide variety of youth-oriented programs across fields. Experienced programs have cited that students often fail to bring consent forms home to their parents\textsuperscript{7}. Whether this is intentional or not is difficult to conclude in any study, but appears to vary with age group; studies indicate that younger children are more compliant in the consent form process, while their older counterparts are more likely to throw away, lose, or hide the forms\textsuperscript{14}. Even when forms are not actively discarded, information commonly gets misplaced or ignored in a backpack\textsuperscript{6}. It is clear that programs cannot assume forms administered to children will ever be seen by parents, let alone read, signed, and returned.

Given the relatively low priority of oral health in our country, it is regrettably consistent that many students would not prioritize returning forms for their participation in a dental program. If children’s oral health is a matter generally unconsidered or misunderstood by the American population\textsuperscript{15}, it cannot be surprising that children themselves would undervalue the importance of their participation in dental programs; ultimately, this situation makes it much more likely that children will forget about the forms in their backpacks. Parents are comparably more receptive to information regarding the child’s health. In terms of school-based programs, return rates have been observed to be substantially higher when consent forms and accompanying materials are dispensed directly to parents rather than to students\textsuperscript{16}.
ISSUE IV: SCHOOL SPONSORSHIP

Every year, more than 51 million school hours lost due to dental-related problems. Furthermore, poor oral health status makes children more likely to experience dental pain, which has been shown to negatively impact school performance. Considering these findings, school administrators are certainly stakeholders in the mission to reduce childhood oral disease. It is important that they be made aware of the increased risk faced by students from low-income families, and develop a working knowledge of the services available to improve their students’ oral health; at the very least, they should understand the role of sealants and fluoride varnish treatments in preventing childhood oral disease. Unfortunately, this understanding cannot be expected; in practice, programs have found difficulty in convincing school administrators and other faculty members that the dental intervention was warranted as a worthy interruption of the school day. When teachers and other staff members do not value the program, they may view it as an intrusion of their time.

It is difficult to overestimate the influence that the attitudes of teachers, administrators, and other school staff members can have on school-based dental program outcomes. Smiles Across America® partner, The Montana Oral Health Foundation, explained how variable support across different schools affects participation: while certain schools showed overwhelming support for the program, some even holding “dental pep rallies” to get students enthusiastic about oral health, other schools do not make consent forms a high priority; at evaluation time, this difference in school sponsorship is “greatly reflected in participation numbers.” This suggests that consent form return rates are directly related to the degree to which school faculty members support the program. For a school-based oral health program, success truly depends on the extent to which the school fully adopts and sustains the program; this backing necessarily requires that the school dedicate time and resources to promoting the program, because it is challenging to find an effective promotional method that doesn’t require any time from the already-busy school schedule.

Across many programs, a trend has emerged regarding school sponsorship: success is the product of one enthusiastic school faculty member taking ownership for the logistical planning and promotion of the dental program. From within the school system itself, this individual serves a pivotal advocate for the importance of children’s oral health. Still, while this singular patronage is admirable, it introduces a degree of instability to the program; a challenge arises when the school loses this sponsor to retirement or otherwise. New York University’s NYC Smiles program experienced the repercussions of this type of loss; when the longstanding “dental champion” from one of its schools retired, the program at that school suffered from a dramatic decrease in consent forms returned. Even more unfortunate, this school’s principal
expresses minimal interest in supporting the program. Situations like this demonstrate the problem of sustainability confronting programs backed primarily by one individual, and underscore the importance of sponsorship embedded deeper within the school system itself.

**ISSUE V: COMMUNICATION**

Effectively engaging school staff has been recognized as a critical factor in establishing necessary communication between parents and project\(^{21}\); they serve as the key intermediary between the program and the home. As the middleman, the school is equipped with the contacts and resources to broadcast information about the dental program. Despite this position, however, longstanding communication issues between schools and homes may confront school-based dental programs with a complicated obstacle.

Communication problems between the school and the home tend to be highly nuanced. In some studies, parents in focus group discussions have complained of poor communication with schools in general, while others specifically mentioned dental programs as well; in fact, many parents had not heard about the problem at all\(^{6}\). It is worth noting, however, that at all of the schools involved, flyers were sent home with children; again, this reveals the difficulty in relying on students to act as messengers of the information. Still, at these same schools, teachers revealed their initial concerns about a general lack of parental involvement, and expressed doubt regarding the likelihood that consent forms would be signed and returned\(^{18}\). Given this evidence of mutual uncertainty, it is clear that a communicational rift exists within many school systems, resulting in a challenging ambiguity for external programmatic planning efforts.

The common communication woes between schools and parents can rarely be singularly blamed on either party; the issue finds roots on both fronts. Ultimately, though, schools are in the critical position, at least in the context of dental programs; school administration and faculty members have the familiarity and necessary connections to fully disseminate information about these programs. If school staff are not proactive about reaching out to households, school-based and school-linked dental programs cannot operate effectively; in this way, communication problems are intrinsically related to school sponsorship.
BEST PRACTICES

WHO?

School Administrators

School-based oral health programs involve multilayered connections of cooperation and communication between students, parents, project personnel, and school staff and administration. Among all of these entities, however, the role of school staff appears to be the most noteworthy determinant of program success. The support level of administrators and teachers has been recognized as the differentiating factor between low and high response rates; in particular, schools with the highest rates of consent form return tend to have administrators who are personally invested in the project in question. Thus, appealing to the administrative offices, especially that of the principal, is vital in establishing a sustainable program within any school. Effectively enlisting the assistance of the principal and other school administrators is so central to program success not only because they are proficient in following up with parents, but also because they are in a position to monitor the consent form return process and provide teachers with necessary support and encouragement.

In this way, the school administration provides a centralized backbone with the expertise and infrastructure needed to sustain the dental program. Recruiting these figures to become fervent advocates of the dental program helps in propagating sponsorship throughout the school system and community. Ultimately, because of its unique position and resources, the ideal function of the administration is twofold: a contact point for the dental program personnel, and a promotional figure for the teachers and parents. Reaching the administrators is the key to creating the environment of support and encouragement, which is fundamental to building a sustainable program. Specifically, principals can help stress the importance of the project to teachers, who are also pivotal players in the overall production.

To initiate faculty engagement, it is recommended that a preliminary meeting be held at the school to briefly discuss the relevance and importance of the program with teachers; moreover, an important characteristic of this meeting is that the school principal be in attendance. In addressing this audience, the link between health and academic performance should be emphasized. More specifically, teachers should be informed of how childhood oral disease and pain manifests in a staggering number of school hours lost annually, and also how the program services will help to improve this dire situation. Because teachers will have a gauge of their classroom dynamic and the most regular communication with students, they play an important role in the process of permission slip returns; when students are responsible for carrying forms to/from home, it is helpful for them to receive daily reminders from their teachers to return signed paperwork. Ultimately, teachers will be more proactive about


collecting slips when they fully appreciate the potential impact of the dental services on students' academic performance and overall wellbeing.

Thus, the demanding task of generating principal and teacher enthusiasm also tends to be the most rewarding one, as it fosters the sense of school-level ownership necessary in establishing a sustainable dental program.

**School Nurses**

Where appropriate, recruiting the assistance of a School Health and Wellness Director has helped programs gain the attention of principals and teachers\(^\text{25}\). In many cases, the school nurse fulfills this role. Building a relationship with the school nurse is essential and collaboration should be solicited at the earliest stages of program inception; some programs even cite this as the “most critical factor” in achieving a successful response rate\(^\text{29}\). One reason these nurses become focal to school-linked health projects because their wealth of resources enable them to identify children who are at highest risk\(^\text{26}\); they are adept at following up with the parents of these children, and therefore improve the program’s capacity to serve the children in greatest need. For example, in following up with students who have not returned a consent form, some programs recommend having the school nurse call parents to ensure that they are aware of the free services\(^\text{27}\). Under extreme circumstances, the nurse may submit a referral for project staff to call parents, and even follow up with a home visit to assist in filling out paperwork; this system is especially applicable for non-English speaking parents\(^\text{28}\). Despite the varying specifics of their roles across programs, a common trend emerges: school nurses are vital to school-based health programs, and dental programs are no exception. Ultimately, in the mission to inspiring collective school enthusiasm about improving children’s oral health, it is intuitive to enlist the cooperation of an individual who is already dedicated to students’ health and wellbeing; he or she will likely be most receptive to the mission of the dental program. Because the greatest obstacle in gaining school sponsorship is persuading the staff of the urgency of the children’s oral health crisis, the school nurse often serves as a central player in building momentum for the project.

It is likely that the reputability attached to the positions of school staff members functions to provide a familiar credibility that reassures parents of the legitimacy of the dental program. Even where communication may be lacking between the school and the home, no school-based or school-linked dental program can realistically function without some degree of support from the school itself. Ultimately, sustainable support is dependent on “community buy-in,” meaning the perceived value of the program among the relevant population. Convincing the community that oral health should be prioritized is not a task to be underestimated; however, this effort lays the foundation for embedding the dental program within the regular school program and infrastructure.
WHAT?

Incentives

Despite the intrinsic value of school-based dental programs, providing stakeholders with additional incentives has been shown to produce higher return rates; schools that offer simple and inexpensive incentives in exchange for returned consent forms have comparatively better return rates than those schools that do not offer incentives. Small prizes such as pencils, stickers, and coupons for free food items during lunch suffice in improving returns.

Incentive offers may by either individualistic or classroom-based, and the relative success between these two standard models appears to be directly related to school structure; the classroom incentive tends to be more effective in the elementary school settings, in which self-contained classrooms create an environment of group motivation. In practice, many programs report success using a classroom-based approach; working with teachers to create a “classroom challenge” manifests a sense of teamwork in pursuit of a common goal, driving more students to return permission slips. The group incentive itself is flexible, but variations of food “parties” have emerged as a common practice; for example, hosting a pizza party for the classroom with the highest return rates has been cited as an effective improvement strategy.

Under circumstances of low program funding, local organizations may be willing to provide incentives, so it is worthwhile to investigate these avenues. Even where this option is not viable, however, creative alternatives have been proven to be effective substitutes for tangible incentives. For example, teachers may offer incentives of their own as appropriate, such as early lunch passes and extra credit points. Furthermore, teachers themselves may also be the target of incentives; some programs recommend offering gift cards to teachers with the highest classroom return rate as a best practice method.

Reminders: Audible and Visible

To reach a satisfactory rate of returns for parental consent forms, various forms of audible reminders are often useful in achieving results. A simple method requiring minimal effort is to broadcast a reminder about the dental program over the intercom at school. Still, this announcement would reach only the ears of the students; as discussed, relying solely on student proactivity is scarcely a reliable approach. Calling the parents of students who failed to return forms has been shown to greatly increase participation numbers. A brief automated phone message reminding parents or guardians of the program services and relevant dates can help increase returns. Some programs have used a Connect-Ed phone messaging system to simply announce to parents that permission slips are being sent home that day in children’s backpacks. Similar approaches include using a “shout out” phone reminder as a notification for parents to look in their children’s backpacks for the permission slip. For both school
announcements and automated phone messages, it has been recommended that dental program staff provide school faculty members with a pre-written segment, lessening the task demanded by the school itself. In addition to these automated reminders, it has been recommended that follow up phone calls be made to parents of students who have not returned a signed form after the second distribution\(^3\). While this step certainly involves additional time and effort, it can prove worthwhile if resources allow.

In addition to verbal cues, visible reminders have proven helpful in increasing participation rates. A poster or similar physical notice placed in a prominent location in the school can serve to remind students of the program. Large, brightly colored signs placed around schools has been cited as a best practice\(^2\). In classrooms, this reminder may take the form of a “Bring Back Board,” displaying representations of each individual student to indicate who has and who has not returned a permission slip\(^3\); in this way, the individual accountability of each student is recognized. Where classroom-based incentives are used, this method may also inspire group reinforcement, and consequently improve return rates.

Again, it is important to be cognizant of the fact that visible reminders placed in schools will likely not be seen by parents. For elementary students, a creative means of reaching parents is to place a sticker on the shirts of students to notify parents that they should look in their child’s backpack for a consent form\(^2\); by this method, less responsibility is placed on children to transmit messages.

**Forms**

The presentation of the parental consent form itself is certainly a significant factor to consider when evaluating the return process; specifically, choices of format and language can influence parents’ receptiveness to the paperwork. Simplifying the forms and removing any “excess verbiage” has been suggested to improve approachability of the information\(^3\). Moreover, adopting the Plain Language concepts presented by the Health Resources and Services Administration has improved return rates in some schools\(^4\); this toolkit was designed as a tool to help healthcare professionals communicate effectively with the general public, and is thus provide potentially useful instructions for any school-based dental program.

Additionally, a discussion of language would be incomplete without recognition of non-English language use within the United States; this concern is particularly relevant in the context of school-based dental programs, in light of the aforementioned research indicating the disproportionate incidence of oral disease on minority populations; consequently, there is an increased vulnerability among children from these groups. To accommodate for non-English speaking parents and those whose first language is not English, permission slips and any accompanying information should be made available in the native language of these populations\(^4\).

Beyond the linguistic style of the paperwork, the quality and quantity of its substance is certainly a determinant of parental response. Including a cover letter from the school’s
principal with permission slips may improve return rates by acting as legitimizing proof of school sponsorship\textsuperscript{38}. Importantly, the paperwork must contain adequate information about the dental services and treatments provided by the program. A common recommendation is to attach an informational brochure to the permission slip itself\textsuperscript{7,39}; in practice, this can simply take the form of a brief, three-sentence description of the program has sufficed in improving parental response. The content of this short statement should succinctly communicate what each child can expect to receive at the event, and also clarify the benefits of these services; moreover, it should be clearly stated that the services are “FREE”\textsuperscript{39}. Additionally, making the forms “eye-catching” can increase the chances that forms will be returned; more specifically, printing the cover letter and/or informational brochure on colored paper serves as an effective indicator to draw students’ and parents’ attention, and may therefore increase the likelihood that the permission slip makes it out of the backpack\textsuperscript{18,35}.

WHEN?

Form Distribution

A strong relationship has been observed between the return rates of parental consent forms and the timing of distribution. Studies have shown that the beginning of the school year is the optimal time to handle the consent form process, because this is the point in the academic year when parents anticipate receiving important school information and are most receptive to this paperwork\textsuperscript{14}. Across programs, this strategy is widely recognized as a best practice. In schools or districts that host a back-to-school fair prior to or at the beginning of the academic year, it has been recommended that dental program staff make permission slips available at this venue\textsuperscript{35}; not only are parents prepared to receive important information at these events, but this situation also facilitates the return process by eliminating the insecure delivery to and from home. Even in contexts where this back-to-school event suggestion is not relevant, the beginning of the school year is still commonly regarded as the best time to distribute forms. Most schools circulate some type of “Signature Packet” within the first week of the academic year, and including parental consent forms for the school-based dental program in this collection of paperwork has been widely noted as an effective strategy for increasing participation\textsuperscript{20,28,37,38}, since implementing this distribution approach, these programs claim to have increased return rates dramatically. Furthermore, this piggybacking with established form collection periods lessens the task of children as information carriers.

Likely due to the heightened level of parental receptiveness to school information at the beginning of the academic year, school programming during the first half of the year tends to have higher participation rates\textsuperscript{21}. Given this finding, it may be strategic for dental programs to
schedule schools anticipated to have lower participation rates for visits at the beginning of the year.30

Follow Up

It is always important to be conscious of the fact that any school-based dental event is one part of a busy school calendar; adopting this perspective, program staff should recognize that following up with participating schools to monitor logistics will be necessary, especially regarding the permission slip return process. Studies have shown that it often takes up to four weeks to achieve a successful rate of form returns31,34; thus, programs should ensure that permission slips are issued four weeks prior to the scheduled date of the school-based dental event. Given this four-week timeframe, it is advisable that program staff communicate with the contact at each school at the mid-way point—two weeks after initial dispensation—to get an estimate for how many forms have been returned, and how this number compares to the goal quota30. In addition to gauging these numbers, the program should ask to see if any further assistance is required in helping the school meet its goal figures36. At this point, all paperwork should also be reprinted and redistributed to students who have not yet returned a signed permission slip30; it is particularly important that this reprinted version includes the words “Second Notice” in a prominent location on the form27,30,32. If the second distribution still does not yield desired return rates, a third distribution might produce slight improvement; however, three distributions tends to be the maximum number of efforts that results in any significant increase in retrievals30.

WHERE?

Form Placement

In addition to the layout and content of the parental consent forms, their intentional placement and distribution have considerable influence on return rates. As previously mentioned, the dental program should make permission slips available at any back-to-school fairs or open houses at the beginning of the school year34,32. Because parents will presumably be in attendance at these events, reaching them at these locations eliminates the need for children to act as messengers in carrying important information; thus, a potential issue is circumvented. Where applicable, program staff should also try to connect with local health fairs and influential health organizations in the area to investigate potential collaboration, thereby expanding their capacity to reach all relevant populations39. Finally, if no relevant school or health-related event can be accessed, having teachers place paperwork directly in the backpacks of children has been cited as a best practice27. Additionally, posting the permission slip online may improve accessibility and alleviate the role of children as information carriers.
Program Staff

With such extensive discussion on the role of school faculty in the dental program, the appropriate engagement of program staff should be addressed. It can often be difficult for project staff to enter individual classrooms, due to scheduling or other logistical complications. Still, it is important that students be informed of the dental program prior to the day of the event. Where the administration will permit and scheduling allows, education presentations in schools before the dental program visit represent an efficient means of reaching the entire student body. To best improve the overall consent form return rate, it is recommended that these presentations be given in schools approximately two weeks before the event. Referring back to the four-week model, this presentation would thus take place at the critical halfway point, at the same time forms were reprinted and redistributed. Ultimately, face-to-face communication is the most effective way to educate students about oral hygiene, and also to stress how important it is that they bring permission slips home to their parents so that they can participate in the dental event. That being said, face-to-face contact can help to reassure parents, as well; for this reason, it is recommended that program representatives attend any community outreach events and/or school events, such as open houses or conferences; giving parents the opportunity to ask questions directly and personally connect with the program typically increases their trust level, and by extension, the likelihood that they will sign a permission slip.

Under circumstances in which it is not feasible for project staff to make site visits and give presentations to the schools on their programmatic calendar, the topic of broadcasting avenues must still be addressed with school administrators. All of each school’s available media outlets should be resourced; more specifically, posting information about the school-based dental program on the school’s website, calendar, newsletter, and even lunch menus can have a positive impact consent form return figures. Ultimately, the program should attempt to saturate the community through all means possible to emphasize the importance of permission slip returns.

Concluding Remarks

Despite the seemingly overwhelming barriers that prevent so many school-based dental programs from obtaining successful permission slip return rates, new programs should not be discouraged; a trend has been observed in which consent form return rates are directly related to how longstanding the program is in the school. Thus, the situation tends to steadily improve as “community buy-in” is fostered over time. Oftentimes, low return rates indicate a broader issue of deficient oral health awareness among parents. Cultivating sustainable school sponsorship for the dental program is a positive step in improving the oral health literacy of all stakeholders. Ultimately, inspiring a sense of ownership for the oral health status of
children within any community is a gradual process, but it is the surest way to build a sustainable school-based dental program.


8CHRISTUS School Based Health Centers. (31 March 2014). *Smiles Across America * 2013-2014 Mid Year Report

9CHRISTUS School Based Health Centers. (7 July 2014). *Smiles Across America * 2013-2014 End Year Report


Massachusetts Department of Public Health. (2008). *Public Health Dental Hygienist Toolkit*


