Florida Department of Health in Clay County School-Based Dental Sealant Program

School Name: _____ Teacher Name: _____

Dear Parent/Guardian:

A **free** Dental Sealant Program will be coming soon to your child's school. This program is available to Elementary School students and helps prevent tooth decay. A licensed Florida dental hygienist will look at your child's teeth and decide which back teeth need to be sealed. Those teeth will be coated with a dental sealant and a fluoride treatment given. Your child will not be given any sedatives, medications, fillings, or x-rays. A sealant is a thin plastic coating that keeps food and germs off the chewing surfaces of teeth. Sealants can protect against 85% of chewing surface cavities. Dental sealants are safe, painless, and simple to apply. Dental sealants are approved and recommended by the American Dental Association, Centers for Disease Control and Prevention, and the Florida Department of Health.

PLEASE RETURN THIS FORM TO YOUR CHILD'S TEACHER TOMORROW

___Yes, I give my child permission to receive a dental screening/assessment, sealants (if applicable), and fluoride varnish.

___No, I do not give permission for my child to be seen.

Name of Child: _____Date of Birth:_____ ☐Male ☐Female ☐Unspecified

Address:_____City:_____Zip Code:_____

Race/Ethnicity: ☐White ☐Black/African American ☐Asian ☐Hawaiian/Pacific Islander ☐Hispanic ☐American Indian/Alaskan Native ☐Other

Select your child's insurance: ☐Medicaid ☐Florida Healthy Kids ☐CMS ☐Private Insurance ☐Other ☐None

My child has a dentist: ☐No ☐Yes Name of dentist: _____Date of last dental exam: _____

Child's Parent/Guardian's Name: _____ _____
Relationship

Telephone Home: _____Cell: _____Work:_____

CHILD'S HEALTH HISTORY

Please **check YES or NO** for each of the following regarding your **child's health**: (check all that apply)

	YES	*NO*
History of rheumatic fever? ☐ Heart murmur?☐ Asthma?☐		☐
My child needs to take antibiotics (e.g. amoxicillin) before dental care: _____	☐	☐
My child cannot take or is allergic to the following medications or materials: _____	☐	☐
My child has the following health problem(s): _____	☐	☐
My child is taking the following medication: _____	☐	☐
My child was hospitalized in the last 2 years for: _____	☐	☐
My child experienced the following unfavorable reaction from previous dental treatment: _____	☐	☐

Please add any comment or additional information: _____
_____

I certify that I have READ and UNDERSTAND the above questions and have answered them to the best of my knowledge. This dental care may include: dental screening/assessment, sealants, fluoride, and oral health instructions. I understand that my child is not being provided other dental care that she/he may need. These services are not a substitute for a comprehensive dental examination. I authorize the dental providers to receive payment from any insurance or any third-party payor that covers the services provided to this patient. Services will be provided to all children at no cost to the parent. Your child may also be examined next year as part of our monitoring program. New sealants will be placed, if needed, at no charge to parent. If you have any questions, please contact our office at 904-529-2800

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____