Consent Form for SCHOOL-BASED SEALANT PROGRAM

School:
Date:

Dear Parent/Guardian:

A free Dental Sealant Program will be in your child's school on the date(s) in the box above. This program is available to all 2nd graders and helps prevent tooth decay. A dentist will examine your child's teeth. No x-ray will be taken. The dentist will decide which molars (permanent back teeth) need to be sealed. Those teeth will be coated with a dental sealant. Sealants are safe, painless and simple to apply; and require no anesthesia. They seal out food and bacteria, which can cause dental decay. Sealants are approved and recommended by the American Dental Association.

The School-Based Dental Sealant Program is a project of, and will be provided by, Florida Department of Health in Citrus County Dental Program at your child's school.

PLEASE RETURN THIS FORM TO YOUR CHILD'S TEACHER IMMEDIATELY

By completing this form, I GIVE PERMISSION for my child to receive a dental screening and dental sealants.

Name of Child:_____ ☐Male ☐Female Grade _____
First Middle Initial Last

Child's Social Security Number:_____ Date of Birth: _____
Month/Day/Year

Teacher's Name:_____

MY CHILD HAS DENTAL INSURANCE: ☐ Yes ☐ No MY CHILD HAS A DENTIST: ☐ Yes ☐ No

MY CHILD HAS MEDICAID: ☐ Yes ☐ No CHILD'S MEDICAID #: _____

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

Address:_____ Daytime Telephone: (____)_____
Street City ZIP Code

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? ☐ Asthma Medication:_____
☐	☐	My child needs to take antibiotics (i.e. penicillin) before dental care? _____
☐	☐	My child cannot take or is allergic to the following medications or materials:_____
☐	☐	My child has the following health problem:_____
☐	☐	My child was hospitalized in the last 2 years for: _____
☐	☐	My child is taking the following medications:_____ 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, have answered the questions to the best of my knowledge, and have had all my questions answered. This consent is being given for sealant placement only. I understand that my child is not being provided other dental care that s/he may need. I understand that this Sealant Program will be provided by Florida Department of Health in Citrus County Dental Program at my child's school.

PARENT'S SIGNATURE _____ **Date** _____