

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Rick Scott
Governor

John H. Armstrong, MD, FACS
State Surgeon General & Secretary

Vision: To be the Healthiest State in the Nation

**Consent Form for
SCHOOL-BASED SEALANT PROGRAM**

School:
Date:

Dear Parent / Guardian:

Our records show that your child received one or more sealants last year during our Dental Sealant Program. The Florida Department of Health in Citrus dental staff will be at your child's school on the date(s) indicated in the box above to provide dental sealants to children in the 2nd grade.

During this visit, the dentist would like to re-examine your child and make sure the sealants are still in place. If the dental sealants need to be reapplied, the team will make every effort to reapply at the same time. We will send you a follow-up letter to keep you informed of the status of sealants on your child's permanent first molars.

If you have any questions or would like more information, please call your School Health Nurse.

PLEASE RETURN THIS FORM TO YOUR CHILD'S TEACHER IMMEDIATELY

_____ **YES**, I want my child to be screened for dental sealant need and, *if indicated*, receive dental sealants

_____ **NO**, I do not want my child to participate in the Dental Sealant Program.

Does your child have any allergies? Yes _____ No _____ If yes, please list: _____

Does your child have any medical condition that the dentist should be aware of? Please describe: _____

PLEASE PRINT:

Name of Child: _____ Date of Birth: _____

Teacher: _____ Grade: _____

PARENT'S SIGNATURE _____ Date: _____