FLORIDA DEPARTMENT OF HEALTH
HILLSBOROUGH COUNTY HEALTH DEPARTMENT
DEDICATED TO HEALTH. DEVOTED TO YOU.

Hillsborough County PUBLIC SCHOOLS
Excellence in Education

Dental Sealants at School

Dear Parent,

Your child can get **free** dental sealants at school. This program is for 2nd graders. This program helps stop tooth decay. A dentist will examine you child's teeth. No x-rays will be taken. The dentist will decide which back teeth need to be sealed. Those teeth will be coated with a plastic sealant. Sealants seal out food and bacteria which cause decay. Sealants are safe, painless, simple to apply and stops cavities! Please fill out this form **today**. Your child must return this form to his/her teacher.

PLEASE CHECK EITHER YES OR NO

☐ **Yes**, I want my child to receive **SEALANTS**. (Please fill in the entire form, sign below and return form).

☐ **No,** I do not want my child to receive **SEALANTS**. (Please fill in name, sign below and return form).

Child's Name: _____ Sex: M F
First name Middle initial Last name

Address: _____
Street City State Zip Code

Date of Birth _____/____/_____ **Social Security #**_____/_____/_____
Month/Day/Year

Race/Ethnicity: ____White _____Black/African American _____Hispanic/Latino _____Asian
_____American Indian/Alaskan Native _____Native Hawaiian/Pacific Islander _____Other

Parent/Guardian Name: _____

Home or Mobile phone: _____ School Name: _____

Does your child receive Medicaid? **Yes No** Child's Medicaid number _____

Does your child have other dental insurance? **Yes No** If yes, please list_____

1. Is your child under the care of a doctor? **Yes No**
   If yes, for what reason _____
2. Is your child taking any medication/drugs? **Yes No**
   If yes, what medicine is being taken? _____
3. Does your child have asthma? **Yes No**
4. Does your child have any serious illnesses? **Yes No**
   If yes, please explain _____
5. Do you have a family dentist? **Yes No**
   Dentist's name _____

I, authorize Suncoast Community Health Centers, Inc. or Tampa Family Health Centers, Inc., to provide dental care to my child at school or at the facility or place where the child is located. This dental care may include: dental exams, sealants, and fluoride. On behalf of myself and/or the patient, I authorize the dental providers to receive payment from any insurance or other third party payer that covers the services provided to this patient. Services will be provided to all children at no cost to the parent. These services are not a substitute for a comprehensive dental examination. Please have your child get a regular dental check up.

Signature of parent or guardian: _____ DATE: _____

Suncoast Community Health Centers Inc.
The Best Healthcare Under the Sun

Tampa Family Health Centers