Dental Sealants at School

Dear Parent,

Your child can get **free** dental sealants at school. This program is for 2nd graders with a potential follow up in 3rd grade. This program helps stop tooth decay. A dentist will examine your 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 ____

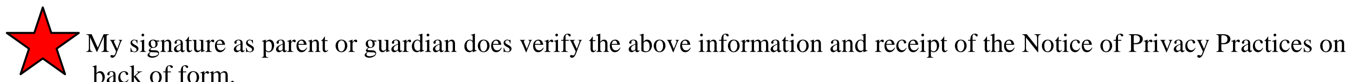
2. Is your child taking any medication/drugs? **Yes** **No**
If yes, what medicine is being taken? ____

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 Tampa Family Health Centers, Inc. or Suncoast Community 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. Your child may be chosen to be reevaluated in 3rd grade for sealant retention and sealant(s) may be reapplied at the follow-up visit in 3rd grade. 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.


My signature as parent or guardian does verify the above information and receipt of the Notice of Privacy Practices on back of form.

____ DATE: ______________

Hillsborough County School District Sealant Program

Date: ____________________

Child's Name: ____ **D.O.B.:** ____/____/____

Dental Provider: _____ Tampa Family Health Centers _____ Suncoast Community Health Centers

"Make Your Smile Count" Oral Health Screening Form/School Children

Screen Date: / /	**Location:**	**Screener's Initials:**
Gender: 1=Male 2=Female	**Grade:**	**Age:**
Race/Ethnicity: 1=White 2=Black/African American 3=Hispanic/Latino 4=Asian 5=American Indian/Alaska Native 6=Native Hawaiian/Pacific Islander 7=Multi-racial 8=Unknown		
Untreated Cavities: 0=No untreated decay 1=Untreated decay	**Treated Decay:** 0=No treated decay 1=Treated decay	
Sealants on Permanent Molars: 0=No Sealants 1=Sealants	**Treatment Urgency:** 0=No obvious problem 1=Early dental care 2=Urgent Care	

Dear Parent,

As you requested, your child has received dental sealants at his/her school. Sealants were placed on tooth numbers ________________________________ to prevent cavities from forming.

_____ SEALANTS WERE NOT PLACED because your child:

____ was absent ____had no teeth that needed sealants at this time ____ was unable to tolerate the procedure

When the dentist checked your child for sealants, he/she felt that your child had the following need for dental treatment:

____ Need for immediate dental treatment due to a toothache or infection. Please take your child to a dentist right away.

____ Need for early dental treatment due to obvious cavities. Please take your child to a dentist as soon as possible within the next few weeks.

____ No obvious need for dental treatment at this time. Your child should, however, visit a dentist at least once a year for a more complete examination including x-rays, if necessary.

Please tell your dentist that your child has had dental sealants applied to his/her teeth. This sealant program does not take the place of regular dental visits. Please have your child get regular dental check-ups.

Provider Signature: _____________________________________ License number ________ Date:___________