Teacher Name:_____ School Name:_____

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 Lake County Dental Program at your child's school.

PLEASE RETURN THIS FORM TO YOUR CHILD'S TEACHER IMMEDIATELY

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

___No, I do not give permission for my child to be seen because of the following reason: _____

Name of Child: _____ ☐Male ☐Female Grade _____

Date of Birth: _____ Age_____

Check all that apply: ☐White ☐ Black/African American ☐ Asian ☐ Hawaiian/Pacific Islander ☐Hispanic ☐American Indian/Alaskan Native ☐ Other

Check which applies: ☐ Dentaquest ☐ MCNA ☐ Argus ☐ Private Insurance ☐ Other ☐ None

My child has a dentist: ☐ Yes Name of dentist_____ ☐ No

Date of last dental exam_____

Child's Parent/Guardian's 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. 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 Lake County Dental Program at my child's school. On behalf of myself and/or the patient, I authorize the dental providers to receive payment from any insurance or any third party payor that covers the services provided to this patient. I understand there is no out-of-pocket expense for these services for any child.

PARENT'S SIGNATURE _____ **DATE** _____ OVER→