



CONSENT FORM FOR SCHOOL DENTAL PROGRAM

Dear Parent,

Your child can get **free** dental sealants without leaving school. This program is for 2nd graders with a potential follow up in 3rd grade. This program helps stop tooth decay. Only a licensed dental professional will screen your child's teeth. No x-rays will be taken. Only a licensed dental professional 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, and simple to apply and stops cavities! Please fill out this form **today**. **Your child must return this form to his/her teacher**. If you have any questions, please call 813-373-8665. Children who do not have insurance including Medicaid will be covered by the Florida Department of Health in Hillsborough County. Children identified as needing follow up dental services will be referred to a dental home (provider).

PLEASE CHECK EITHER YES OR NO

- Yes**, I want my child to receive a dental screening, fluoride varnish and sealants (if applicable).
- No**, I do not give permission for my child to be seen because of the following reason: _____

Child's Name: _____ Sex: M F

First name Middle initial Last name

Address: _____
Street City State Zip Code

Date of Birth ____/____/____
Month/ Day /Year

Home or Mobile Phone: _____ **School Name:** _____

Race: ____ White ____ Black/African American ____ Asian ____ American Indian/Alaskan Native
____ Native Hawaiian/Pacific Islander ____ Two or more races ____ Other ____ No Response

Ethnicity: ____ Hispanic/Latino ____ Not Hispanic/Latino ____ No Response

Parent/Guardian 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. Does your child have asthma? Yes No
2. Does your child have any serious illnesses or allergies to acrylics/plastics? Yes No
If yes, please explain _____
3. 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. This dental care may include: dental screening, sealants, and fluoride, and a potential follow up visit in 3rd grade for sealant retention and sealant replacement. 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. I authorize screening results to be shared with the Florida Department of Health in Hillsborough County. The services being offered are not a substitute for a comprehensive dental examination by a dentist. The diagnosis of caries, soft tissue disease, oral cancer, temporomandibular joint disease (TMJ), and dentofacial malocclusions will be completed only by a dentist in the context of delivering a comprehensive dental exam. Please have your child get a regular dental checkup.

 **Signature of parent or guardian to verify the above information is true and correct.**

DATE: _____