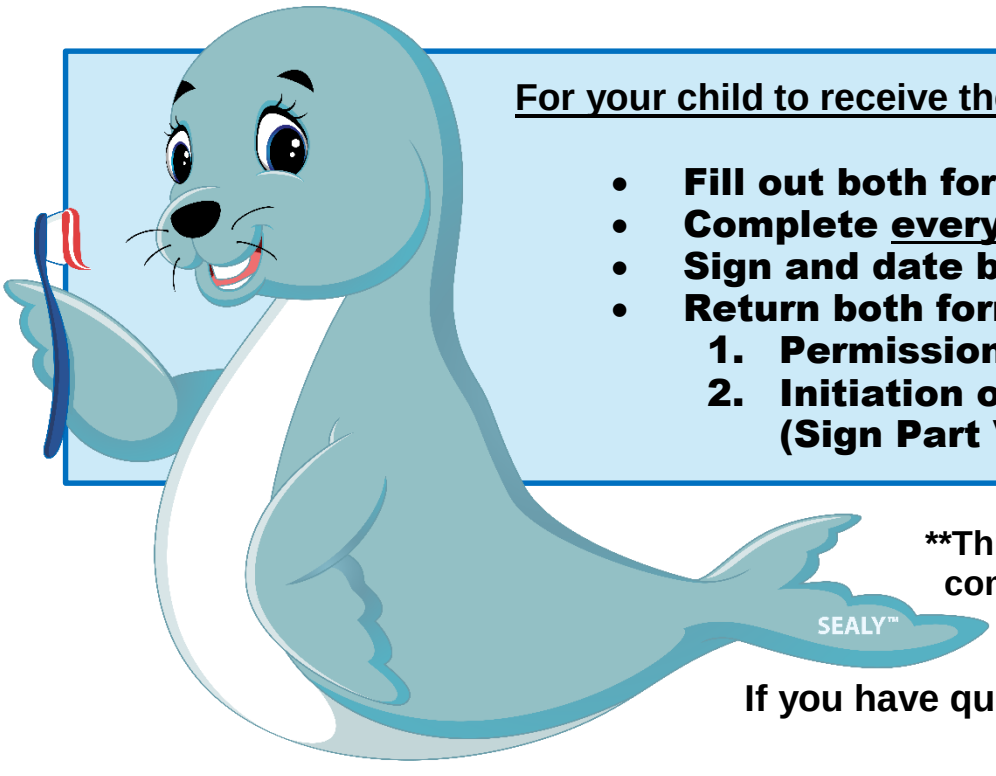
A DENTAL PROGRAM IS COMING TO YOUR CHILD'S SCHOOL!

Your child will receive:

- Dental exam
- Education on how to properly brush his/her teeth
- Dental cleaning (when appropriate)
- Dental sealants (if needed)
- Fluoride treatment
- Toothbrush, toothpaste, flossers, & book about tooth care
- Referrals for follow-up care (if needed)

- A Florida Department of Health licensed dental hygienist will provide these preventive dental services.
- Your child will not be given any shots, medicine, x-rays, or fillings.
- After your child has been seen, a letter will be mailed to your home explaining the services your child received and the follow-up care needed.
- If the Department of Health saw your child last year, you will need to fill out new permission forms for your child to be seen again.
- You will not receive a bill. **This program is at no cost to you.** If your child is covered by Medicaid, the dental services we provide will be billed to Medicaid. Any services not covered by Medicaid are at no cost to you.

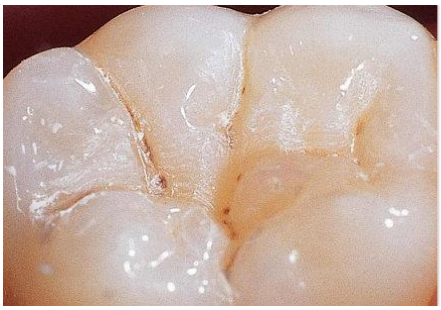


For your child to receive these services you need to:

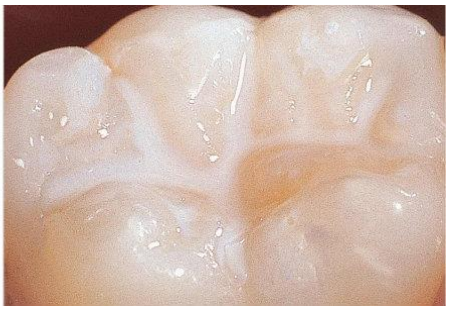
- **Fill out both forms in pen**
- **Complete every question on the forms**
- **Sign and date both forms**
- **Return both forms to child's teacher**
  1. **Permission Form**
  2. **Initiation of Services Form – (Sign Part VII)**

****This program does not replace a complete check-up by a dentist****

If you have questions about this program, please call 954-847-8196



Natural Tooth



Sealed Tooth

What are dental sealants? Dental sealants are thin plastic coatings that are applied to the grooves of the chewing surfaces of the back teeth to protect them from tooth decay. Most tooth decay in children and teens occurs on these surfaces. Sealants protect the chewing surfaces from tooth decay by keeping germs and food particles out of the grooves.

Which teeth are sealants placed on? Permanent molars are the most likely to benefit from sealants. The first molars usually come into the mouth when a child is about 6 years old. Second molars appear at about age 12. It is best if the sealant is applied soon after the teeth have erupted, before they have a chance to decay.

How are sealants applied? The process is short and easy. After the tooth is cleaned, a gel is placed on the chewing surface for a few seconds. The tooth is washed off and dried, and then the sealant is painted onto the tooth. A light will be shined onto the tooth to help harden the sealant. It takes about a minute for the sealant to form a protective shield.

Will sealants make teeth feel different? As with anything new that is placed in the mouth, a child may feel the sealant with the tongue. Sealants are very thin and only fill the grooves of the back teeth.

How long will sealants last? A sealant can last for several years. They can come off sooner if your child eats sticky candy. Sealants should be checked at your regular dental appointment and can be reapplied if they are no longer in place.

How do sealants fit into a preventive dentistry program? Sealants are one part of a child's total preventive dental care. A complete preventive dental program also includes fluoride, twice-daily brushing, healthy food choices, and regular dental care.

Can sealants be placed over cavities? Sealants can be placed over areas of early tooth decay to prevent further damage to the tooth. Because some sealants are clear, your dentist is able to keep an eye on the tooth to make sure the sealant is doing its job.

Why is sealing a tooth better than waiting for decay and filling the cavity? Decay damages teeth permanently. Sealants protect them. Sealants can save time, money, and the discomfort associated with dental fillings.

For more information:

https://www.cdc.gov/oralhealth/publications/faqs/sealants.htm

http://www.mouthhealthy.org/en/az-topics/s/sealants

Return this form to your child's school!

PERMISSION FORM

Florida Department of Health in Broward County
Dental Sealant Program

_____
(School)

_____
(Teacher & Grade)

Please complete ALL sections of this form in PEN

Child's Name _____ **Date of Birth** _____ **Sex** ☐ **M** ☐ **F**
LAST First Middle mm/dd/yyyy

Street Address _____ **City:** _____ **Zip Code**_____

Race ☐ White ☐ Black/African American ☐ American Native/Alaskan Native ☐ Asian ☐ Hawaiian Native/Pacific Islander

Ethnicity ☐ Hispanic ☐ Non-Hispanic **Primary Language** _____

Name of Dental Insurance _____ **ID #** _____

Child's Health History:

☐ **Yes** ☐ **No** **Has your child seen a dentist within the last year?**
If yes, dentist's name:_____

☐ **Yes** ☐ **No** **Does your child have any medical conditions?**
If yes, please list:_____

☐ **Yes** ☐ **No** **Is your child allergic to anything?**
If yes, please list:_____

☐ **Yes** ☐ **No** **Is your child taking any medications?**
If yes, please list:_____

By signing this form I give permission for my child to participate in this preventive dental program that will take place at his or her school.

☐ **Mother** ☐ **Father** ☐ **Legal Guardian**

Parent/Legal Guardian Name (Printed): _____

Signature: _____ **Date:** _____

Telephone: Home _____ **Cell** _____

TURN PAGE OVER
THE NEXT PAGE MUST BE COMPLETED

Return this form to your child's school!

INITIATION OF SERVICES

PART I. CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name (Child's Name): _____
Name of Agency: Florida Department of Health in Broward County
Agency Address: 780 SW 24th Street, Fort Lauderdale, FL 33315

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical office visits including obtaining medical history, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

PART II. DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only**)**
I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART III. COMMUNICATIONS
I understand the Florida Department of Health (DOH) uses a patient portal to communicate with me about my health care. In order to receive electronic communications about my health care, I need to provide my email address to the department and then I will be contacted by email to create a portal account.
I understand that I must agree to the terms and conditions of use associated with the portal when I create my account. I understand that the portal is password protected and that I am responsible for maintaining the confidentiality of my username and password and for all activities that are conducted through my portal account. I understand that I will receive emails letting me know that DOH has sent information to the portal.
_____Initial here to **authorize** and give my express consent to the DOH to make your health care information available to you through the portal.
Email Address: _____
I understand that I have a right to stop participation in the portal at any time by either removing my email address or closing my portal account.
_____Initial here to **remove your email** address from the DOH system and stop receiving information through the portal.

PART IV. MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)
As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART V. ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)
As Client /Representative signed below, I assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART VI. COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER
(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)
For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VII. MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

_____ _____ _____
Client/Representative (Parent/Legal Guardian) Signature | Self or Representative's Relationship to Client | Date

_____ _____
Witness (optional) | Date

PART VIII. WITHDRAWAL OF CONSENT

I, _____ WITHDRAW THIS CONSENT, effective _____
Client/Representative Signature | Date

_____ _____
Witness (optional) | Date

Client Name: _____
ID#: _____
DOB: _____

Original to file; Copy to client