PLEASE RESPOND YES OR NO AND RETURN TO SCHOOL

DENTAL SEALANT PROGRAM CONSENT FORM
TOLEDO LUCAS COUNTY HEALTH DEPARTMENT

- 2nd, 3rd, 6th, 7th, & Sp. Ed students can receive FREE dental sealants at school during the 2016-17 school year.
- Sealants are a safe, BPA-free plastic coating applied to permanent 6 and 12 year molars to help prevent cavities.
- A licensed dental hygienist will check your child's teeth and apply sealants, if needed.
  If your child has sealants, they will be checked and repaired if needed; newly erupted teeth will also be sealed.
- Your child will bring home a letter regarding their dental health.
- Your child will be checked again next school year and sealants applied, if needed.
- This free program is offered by the Toledo-Lucas County Health Department 419-213-4266

CHILD'S NAME_____ ☐ MALE ☐ FEMALE

SCHOOL_____ GRADE_____ ROOM_____TEACHER_____

☐ YES, I give my consent for my child to receive a dental screening and dental sealants at school.
PLEASE COMPLETE ENTIRE FORM AND SIGN BELOW. Thank you.

☐ NO, I do not want my child to have sealants. STOP here and SIGN: _____

CHILD'S DATE OF BIRTH_____/_____/_____ CHILD'S S.S. #_____-_____-_____

ADDRESS_____CITY_____ZIP_____PHONE_____

Does your child receive free or reduced lunch at school? Yes ☐ No ☐ Don't Know/Don't Remember ☐
Does your child have any serious health problems? Yes ☐ No ☐
If yes, please explain_____
Is your child allergic to acrylics/plastics? Yes ☐ No ☐
Name of family dentist: _____

Check all boxes that apply.	ETHNICITY	RACE					
	Hispanic	American Indian/ Alaskan Native	Asian	Black/ African American	Native Hawaiian / Pacific Islander	White	Other	Unknown

No payment is required from you for this program. It is made possible through federal grant funding and billing of government-based insurance. If your child has insurance coverage through one of the insurances below, please provide information found on your child's card.

☐ PARAMOUNT ADVANTAGE ☐ buckeye health plan ☐ CareSource ☐ UnitedHealthcare Community Plan ☐ MOLINA HEALTHCARE ☐ Other Medicaid

Billing # or ID #_____MMIS #_____

I have read and completed the information above and my signature below gives consent for treatment and is valid for 24 months. I have read and understand the Notice of Privacy Practices on the back of this form and know that a copy is available from the school office or at www.lucascountyhealth.com.

➡ PARENT/GUARDIAN SIGNATURE: _____Date_____