No Cost to Parent or Guardian

A Preventive Dental Program is coming to your child’s school.

Your child can receive

- Dental Exam or Assessment
- Education on how to properly brush his/her teeth
- Dental sealants if needed ***
- Fluoride treatment
- Dental Cleaning when appropriate
- Toothbrush, Toothpaste and Toothbrush Timer
- Referrals for follow up care if needed

A licensed dentist or dental hygienist from the Florida Department of Health in Volusia County will provide the services listed above.

Your child will not be given any shots, medications, x-rays or fillings.

After your child is seen, a letter will be sent home informing you what was done and what follow-up care is needed.

If you would like your child to receive these services, you must:

COMPLETE and SIGN and RETURN THE PERMISSION FORM

***Sealants are protective coatings that help prevent cavities on healthy back teeth.

This program does not replace a complete dental check-up by a dentist.
What is a dental sealant?
A sealant is a thin plastic coating that protects the chewing surfaces of teeth from cavities.

When should teeth be sealed?
A sealant should be placed as soon as the permanent tooth appears in the mouth, usually around 5-6 years old, or as soon as possible.

How are dental sealants applied? After the tooth is cleaned, the sealant is painted into the grooves of the back teeth. A special light is used to help the sealant harden.

How long do sealants last?
Sealants will usually last about five years or longer. Sealants should be checked once a year and replaced if needed.

volusiahealth.com/dental
Our dental team is coming to your child’s school.

Dental care is provided at no cost to parents and guardians.

Don’t miss out. We’re only here once a year.

Return the attached consent form today.

Questions? 386-274-0896

volusiahealth.com/dental
Florida Department of Health in Volusia County - Dental Clinic
Preventive Oral Health Program

No Cost to Parent

Child’s Name: ___________________________ Date of Birth _______________ Sex □ M □ F

Street Address ___________________________________________ Zip Code __________

Race/Ethnicity  □ White  □ Black/African American  □ Asian  □ Hispanic
□ American Indian/Alaska Native  □ Hawaiian/Pacific Islander  □ Other

Child Insurance:

Medicaid? □ Yes □ No  Other Dental Insurance □ Yes □ No

Child’s Health History:

□ Yes □ No  Has your child received a dental check-up or dental care within the last year?

□ Yes □ No  Has your child been seriously ill? List all serious illnesses __________________________

□ Yes □ No  Is your child allergic to anything? List __________________________

□ Yes □ No  Is your child taking any medications? List all medications __________________________

□ Yes □ No  Has your child ever been seen in a Hospital Emergency Room for a dental problem?

□ Yes □ No  Is there anything else we should know about your child? If yes, please explain

Parent or Legal Guardian Information

Mother or Father’s Name ___________________________ _______________________

Telephone: Home ______________________  Cell_________________________ Work _____________

Legal Guardian Name ___________________________ _______________________

** If legal guardian, see note below **

Telephone Home ______________________  Cell_________________________  Work ______________________

To protect patient privacy, information about child’s treatment can only be released to parents or legal guardians. I do hereby give consent to the Florida Department of Health in Volusia County, 1845 Holsonback Drive, Daytona Beach, Florida 32117 and their dental representative (dentist/hygienist) to use or disclose protected health information for treatment or Insurance/Medicaid payment. My child will receive: Dental exam/assessment, Oral hygiene Instructions, Dental cleaning if appropriate, Dental sealants if needed and Fluoride treatment. I agree if my child has urgent dental needs, his/her health information can be shared with the school nurse. My signature below verifies the above information.

By signing this form I give permission for my child to participate in this program.

Parent/Legal Guardian Signature ___________________________ Date__________

**Anyone other than a natural parent giving consent for treatment must provide legal documentation of guardianship.

This program will be provided at your child’s school. Your child may also be examined/assessed next year as part of our monitoring program. New sealants will be placed, if needed at no charge to parent. If you have any questions, please contact our office at 386-274-0895