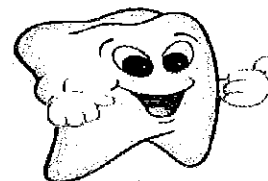
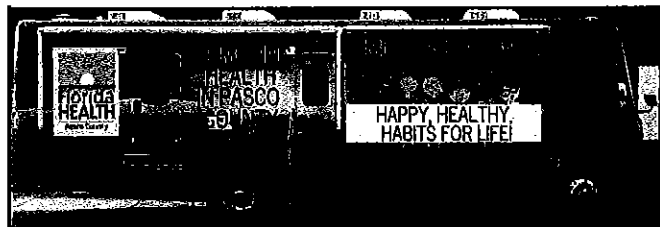


Florida Department of Health in Pasco County Dental Bus Sealant Oral Health Program – No Cost To Parent



**Second, Third, Fourth & Fifth Grade students receive dental assessment, dental sealants, fluoride varnish.
Sixth, Seventh & Eight Grade students receive dental assessment, dental sealants, fluoride varnish.**

Your child will receive a free toothbrush, toothpaste and floss.

School Name _____ Teacher _____ Grade _____

Print Child's Name _____ Date of Birth _____

Street Address _____ Zip Code _____

Race/Ethnicity White Black/African American Asian American Indian/ Native Hispanic Other

Sex Male Female / My child has a dentist: Yes No Name of dentist _____

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? If yes, please explain _____

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

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

My signature below indicates consent for my child to receive the above services, and also is my consent to the sections marked "Initiation of Services" by the Florida Department of Health, the reverse side of this document, and "Hold Harmless, Indemnification, and Release Agreement" for the Pasco County Schools, the reverse side of this document.

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 Outreach Program will be provided by Florida Department of Health In Pasco 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 to me for these services for any child.

RETURN FORM TO YOUR SCHOOL WITH EITHER "YES" OR "NO" FOR DENTAL BUS PROGRAM.

Check Box Yes No **I CONSENT TO MY CHILD'S PARTICIPATION IN THIS PROGRAM.**

Parent or Legal Guardian Information

Print Parent/Guardian's Name _____ Phone No _____

Parent/Guardian's Signature _____ Date _____