PLEASE KEEP THIS PAGE FOR YOUR INFORMATION

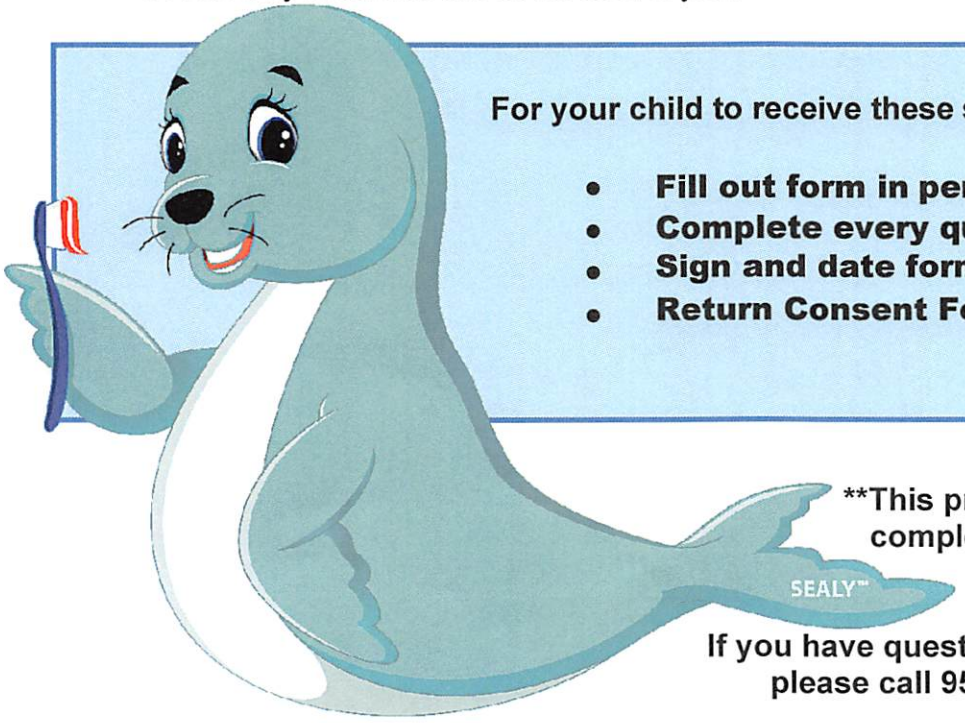
A DENTAL PROGRAM IS COMING TO YOUR CHILD'S SCHOOL!

Florida HEALTH Broward County

Your child will receive:

- Dental assessment.
- Education on how to properly brush his/her teeth.
- Toothbrushing.
- Dental sealants (if needed).
- Fluoride treatment.
- Toothbrush, toothpaste, flossers, and 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:

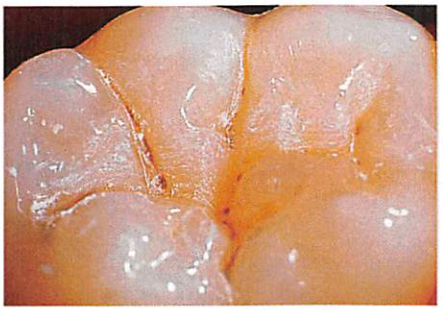
- **Fill out form in pen.**
- **Complete every question on the form.**
- **Sign and date form.**
- **Return Consent Form to child's teacher.**

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

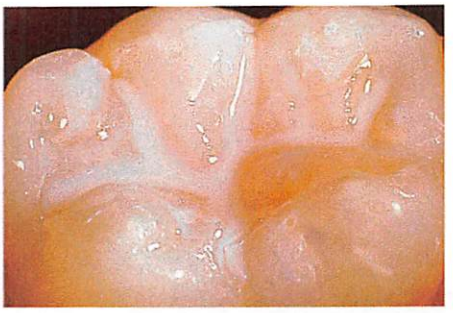
If you have questions about this program, please call 954-847-8196.

Florida HEALTH
Broward County

Dr. Isabel Cruz – DN25330
954-467-4705
For after hours emergency:
954-467-4705



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 through the gum, 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:
FloridaHealth.gov/programs-and-services/community-health/dental-health/sealant.html

mouthhealthy.org/en/az-topics/s/sealants

DOH-Broward DD-49 (Rev. 4/24)

To participate, please tear off this page and return to your child's school!

DENTAL 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** _____

Child's Health History:

☐ 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 verify my rights and responsibilities detailed on the reverse page and give permission for my child to participate in this school based preventative dental program.

☐ Mother ☐ Father ☐ Legal Guardian

Parent/Legal Guardian Name (Printed):

Signature: **Date:**

Telephone: Home _____ **Cell** _____

PLEASE TURN PAGE OVER

TO REVIEW ADDITIONAL TERMS AND CONDITIONS

Florida HEALTH
Broward County

Return this form to your child's school!

INITIATION OF SERVICES

PART I CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: FLORIDA DEPARTMENT OF HEALTH IN BROWARD COUNTY

Agency Address: 780 SW 24 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 visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.
I acknowledge and I consent to the provision of some services to be provided by means of telehealth. I may withdraw my consent at any time by discontinuing the use of telehealth services without affecting my right to future care or treatment.

PART II DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations. Additionally, I consent to my health information being shared in the Health Information Exchange (HIE), allowing access by participating doctors' offices, hospitals, care coordinators, labs, radiology centers, and other health care providers through secure, electronic means. If you choose not to share your information in the HIE, you may opt out by requesting and signing an HIE Opt-Out form.

PART III 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 health 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 IV 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 V 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 VI NOTICE OF PRIVACY PRACTICES

I certify that I have reviewed, understand, and agree to the Notice of Privacy Practices, which states the ways DOH is allowed to use the collected health information and lists the rights which clients have with respect to their health information. The Notice of Privacy Practices is available here:

https://www.floridahealth.gov/about/patient-rights-and-safety/hipaa/_documents/notice-of-privacy-practices-eng.pdf