DAYTON PUBLIC SCHOOLS

Please return this form to your child's teacher

Return to School By:		Consent Reviewed By:
TOMORROW	**Free**	

Free Dental Sealants

Five Rivers Sealant Program/Funding provided by Ohio Department of Health

Dear Parent:

A **free** dental program will be in your child's school. The Program is primarily for **2nd and 6th graders**. Sealants help stop tooth decay. A Registered Dental Hygienist will screen your child's teeth and decide which back teeth need to be sealed. A dental hygienist will then put the sealants on your child's teeth to seal out food and bacteria that cause decay. Your child's sealants will be checked **each year they qualify**. New sealants will be applied if needed. *Please fill out this form today*. Your child must return it to his/her teacher.

We need you to answer YES or NO.

_______ **YES** **I want** my child to receive **Free Sealants each year my child qualifies.**
(*Please fill in the entire form and SIGN below.*)

_______ **NO** **I do not** want my child to receive **Free Sealants.**

Ethnicity: Is your child Hispanic? (Please check) _______**Yes** ________**No**

Race: Please check **all that apply** for your child.

❏American Indian/Alaskan Native ❏Black or African American ❏White

❏Asian ❏Native Hawaiian/Pacific Islander ❏Other

A copy of the most current Notice of Privacy Practices is available by downloading this PDF at **FiveRiversHealthCenter.org**

My child receives ***Free or Reduced Lunch*** ________**YES** _______ **NO** _____ **DON'T KNOW**

Name of Child____

Child's Birthday ____/_____/_____ **Social Security#**_______ _______ ________

Home Phone Number ____

Child's School ______________________________ **Homeroom** ____________

Dentist's Name ____

HEALTH HISTORY

1. Has your child had any serious health problems?	**Yes No**	
If yes, please explain.		
2. Does your child have any of the following allergies?	**Acrylic/Plastics Yes No**	
Other	**Yes No**	**If Yes please list:**

NO PAYMENT IS REQUIRED FROM YOU FOR THIS PROGRAM.

Care Source and the Ohio Department of Jobs and Family Services (ODJFS) may pay for your child's care if you are insured by them. Those funds allow us to provide care to students who have no source of support for dental care. Please take a moment and provide us with the following information if you are covered.

Medicaid / Caresource / Molina **Child's Number**___________________________ ***Please circle correct coverage***

PARENT OR GUARDIAN SIGNATURE REQUIRED.

☺**Signature:** ____ **Date** _____/____/______ **Rev 6/2019**