_____ (Date of Program)

_____ (Return By)

_____ (School)

_____ (Teacher)

Florida Department of Health in Broward County

Dental Sealant Program

FREE to Parent or Guardian

Child's Name: _____ **Date of Birth** _____ **Sex** ☐ **M** ☐ **F**
Last First mm/dd/yyyy

Street Address _____ **City:** _____ **Zip Code**_____

Race ☐ White ☐ Black/African American ☐ American Native/Alaskan Native ☐ Asian Indian ☐ Asian Other
☐ Chinese ☐ Filipino ☐ Guamanian/Charmorro ☐ Hawaiian Native ☐ Japanese ☐ Korean ☐ Samoan
☐ Pacific Islander-Other ☐ Vietnamese ☐ Multi-Racial (Select more than one)

Ethnicity ☐ Hispanic ☐ Non-Hispanic **Primary Language** _____

Child's Dental Insurance:

Medicaid? ☐ Yes ☐ No Other Insurance ☐ Yes ☐ No Child Dental Insurance ID # _____

Child's Health History:

☐ **Yes** ☐ **No** **Has your child received any dental service within the last year?**
If yes, Dentist's Name**:** _____ Phone #: _____

☐ **Yes** ☐ **No** **Does your child have any serious medical conditions?**
If yes, please list:_____

☐ **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 _____

Or **Legal Guardian Name** _____

Telephone: Home _____ Cell_____ Work _____

This preventive oral health program will be provided at your child's school. Your child may also be examined next year as part of our monitoring program. New sealants will be applied, if needed, at no charge to parent or guardian. If you have any questions, please contact our office at 954-467-4700 x 5180.

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

Parent/Legal Guardian Name: (Please Print)_____

Signature:_____ **Date**_____