UF College of Dentistry
UNIVERSITY of FLORIDA

DENTAL SEALANT PROGRAM
CONSENT FORM

SCHOOL: _____ **TEACHER:** _____**GRADE:**_____

Dear Parent/Guardian:
A dental sealant program sponsored by UF College of Dentistry is now available to your child. Dental sealants help prevent cavities on permanent back teeth. Dental providers and students from the University of Florida will examine your child's teeth and decide which teeth can be sealed. The selected teeth will be coated with a plastic sealant, and a fluoride treatment given. Sealants are safe, painless, and easy to apply. (No x-rays or shots are needed for this process). Sealants are approved and recommended by the American Dental Association.
Please circle **YES** or **NO**:

__**YES -**My child has permission to participate in the sealant program.
__ **NO -**My child does NOT have permission to participate in the sealant program.

Name of Child: _____ **Age:** _____
Date of Birth: _____ **[ ] Male [ ] Female**
Address: _____

Please answer the following questions:

1. Is your child currently under a physician's care? __**YES** __**NO**
2. Is your child currently taking any medications? __**YES** __**NO**
   If **YES**, please list: _____
3. Has your child ever had an allergic reaction? __**YES** __**NO**
   Please explain a **YES** answer: _____
4. Does your child have a dentist? __**YES** __**NO -**If **YES,** Name: __
5. My child's most recent dental visit was within the last:
   __6 months __12 months __3 years __5 years __Never seen a dentist

ALL children can participate in this program- whether or not they have dental insurance. We will bill insurance, but NO PAYMENT will be required from you. In order to help us better serve those in need of services, please provide the following information:

6. How do you pay for your child's dental care? Check all that apply.
   [ ] Self [ ] Medicaid (DentaQuest, MCNA) [ ] Florida KidCare [ ] Private dental insurance
   Medicaid or Florida KidCare # _____

7. Select all that apply to your child:
   [ ] White [ ] Black/African-American [ ] Hispanic [ ] Asian/Pacific Islander [ ] Native American [ ] Other

By my signature below, I give permission for my child to have the treatments described above and have received the Notice of Patient Privacy.

Signature: _____ **Date:** _____ **Phone Number:** _____

Photo/Video Release
*I hereby grant to **University of Florida College of Dentistry** the absolute right and permission to use pictures and/or video footage of myself/my child taken for editorial, trade, advertising and any other purpose. With my signature below, I am signing that I understand that there is no payment for any use of the photographs taken.*

Signature:_____