# Ronald McDonald Care Mobile® Dental Sealant Program Consent Form


Dear Parent/Guardian:

The Healthcare Network of Southwest Florida ("HCN") will be sponsoring a dental program in your child's school soon. This program is available for first and second grade students. This program's goal is to stop tooth decay and increase dental health. A dental hygienist will assess your child's teeth and decide which back teeth will need to be sealed. No x-rays will be taken. Selected teeth will be coated with a plastic sealant. Sealants seal out food and bacteria. Sealants are safe, painless, simple to apply, and stop cavities! They are approved by the American Dental Association. Your child may also be examined next year and new sealants will be put on if needed.

HCN will be offering this program at **no cost** to parents/guardians. However, HCN will seek reimbursement from Medicaid and/or other public/private health insurance providers if available. **No insurance is required, but we ask that if you have coverage that you provide us the information so that we can seek payment so that we can continue our program.** Co-pays and the costs for children without insurance will be covered utilizing grant funds or other sources.

Below is the consent form where give us permission to screen and perform sealants for your child, give us permission to seek reimbursement from any insurance you may have, provide us with some background information on your child, and acknowledge receipt of our Notice of Privacy Policies (available at www.HealthcareSWFL.org).

Should you have any questions the HCN Ronald McDonald Care Mobile® Dental Sealant Program contact number is (239) 658- 3013.

**PLEASE RETURN THIS FORM TO SCHOOL IMMEDIATELY.**

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**Consent for Screenings and Sealants**

I, as the parent or legal guardian of the child listed below, hereby authorize HCN, its facilities or treatment centers, its dentists, and/or dental hygienists in charge of my or my child's care, to administer screenings and sealants, as may be deemed appropriate.

Name of Child _____ Date of Birth _____
Telephone _____
Sex (M/F) _____

Other Insurance Info (If Applicable)
Carrier Name: _____ Subscriber/Policy No.: _____

Does your child have any serious health problems? Yes___ No___
Does your child have allergies? Yes___ No ___
Does your child take any medications? Yes___ No___
If yes, please explain: _____

**BY MY SIGNATURE BELOW I ACKNOWLEDGE THE ABOVE AND MY RECEIPT OF THE NOTICE OF PRIVACY POLICIES AND CONSENT TO THE DENTAL TREATMENT OF ABOVE CHILD AND TO HCN SEEKING REIMBURSEMENT FOR SERVICES PROVIDED TO THE ABOVE CHILD.**

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Name (Printed)

_____
Mailing Address City State Zip

Healthcare Network of Southwest Florida
1454 Madison Avenue
Immokalee, FL 34142
239-658-3000

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