

Teacher: _____ Grade: _____

Dear Parent/Guardian:

A **FREE** dental program will soon be available to your child through the University of Florida College of Dentistry. Our program's goal is to help stop tooth decay and increase dental health in young children in our area. We offer dental screenings, fluoride varnish and dental sealants. The dental screening we provide does not take the place of a comprehensive oral exam in a dental office. Your child should see a dentist regularly.

The dental sealants are only offered to those children that are in the 1st and 2nd grade and would benefit from placement. A dentist or dental hygienist will screen your child's teeth and decide which back teeth will need to be sealed. The selected teeth will be coated with sealant material to help seal out food and bacteria, which cause decay. For 1st grade students, we will check the sealants again when they are in 2nd grade to make sure the sealants are still there and apply fluoride varnish. At that time, we will also repair or replace any sealants that have broken or come off. An optional fluoride varnish is also being offered for your child. Sealants and fluoride varnish are safe, painless, simple to apply, and stop cavities!

This program is being conducted in partnership with the Naples Children and Education Foundation and the University of Florida College of Dentistry.

PLEASE COMPLETE, SIGN AND RETURN THIS FORM TO THE SCHOOL IMMEDIATELY

Parent Note: Fluoride varnish should be placed once every three months. If your child has received a fluoride varnish within the last 3 months, at the dentist or pediatrician's office, you should only give permission for your child to receive a dental screening and dental sealants.

Consent for Dental Screening, Sealants and Fluoride Varnish

I, as the parent or legal guardian of the child listed below, hereby authorize the University of Florida Dental Outreach program, its dentists, and/or dental hygienists to administer screenings, sealants and/or fluoride varnish as may be deemed appropriate.

Name of Child _____ Date of Birth: _____ Teacher: _____

I give permission for my child to receive: (Please check only one box below)

Screening/Fluoride/Sealants Screening/Sealants only Screening/fluoride only Screening only

Please answer the following questions:

1. Does your child have any serious health problems? **YES** **NO**
If yes, please explain _____
2. Is your child currently taking any medications? **YES** **NO**
If yes, please list medications _____
3. Has your child ever had an allergy or allergic reaction? **YES** **NO**
If yes, please explain _____
4. Does your child have a dentist? **YES** **NO**
If yes, please provide Dentist's name _____
5. My child's most recent dental visit was within the last: (check ONE)
 6 months 12 months 3 years 5 years Has never seen a dentist

By my signature below, I acknowledge the above and consent to the dental treatment noted to the above child.

Parent/Guardian Name (print): _____ **Phone number:** _____

Parent/Guardian/Signature: _____ **Date:** _____