Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Vision: To be the Healthiest State in the Nation

Rick Scott
Governor

Celeste Philip, MD, MPH
State Surgeon General & Secretary

Español en la parte de atrás

No Cost to Parent or Guardian

A **Dental Program** is coming to your child's school.

Your child will receive:

Dental Program Dates: April 11th – 18th

- Dental Assessment
- Education on how to properly brush his/her teeth
- Dental sealants if needed***
- Fluoride treatment
- Toothbrush, Toothpaste, Floss and Toothbrush Timer
- Referrals for follow up care if needed

A licensed dental hygienist from the Florida Department of Health in Pinellas County will provide the services listed above.

Your child will not be given any shots, medications, x-rays or fillings.

After your child is seen, a letter will be sent home informing you what was done and what follow-up care is needed.

If you would like your child to receive these services, you must

COMPLETE – SIGN – RETURN

PERMISSION FORM on or before April 1st

***Dental sealants are protective coatings that help prevent cavities on healthy back teeth.

This program does not replace a complete dental check-up by a dentist.

Florida Department of Health
in Pinellas County
12430 130th Ave. N. • Largo, FL 33774
PHONE: (727) 588-4040 • FAX (727) 588-4010
FloridaHealth.gov

PHAB Accredited Health Department
Public Health Accreditation Board

Florida Department of Health in Pinellas County Dental Clinic
Preventive Oral Health Program
No-cost to Parent

School:

Teacher:

☐ **Yes I approve of my child's participation in this program**

☐ No I do not approve of my child's participation in this program

Name of Child ______________________________ **Date of Birth** ______________ **Sex** ☐ M ☐ F

Street Address ____ **Zip Code** ____________

Race/Ethnicity ☐ White ☐ Black/African American ☐ Hispanic ☐ American Indian/Alaska Native ☐ Asian Other ☐ Hawaiian Native ☐ Asian ☐ Pacific Islander ☐ Other

Child has Insurance/Medicaid? ☐ **Yes** ☐ **No**

Child Medicaid # ______________ **Child Insurance Carrier** ________________ **ID #** ________________

Child's Health History

☐ **Yes** ☐ **No** **Has your child received a dental check-up or dental care within the last year? Dentist Name:**

☐ **Yes** ☐ **No** **Has your child been seriously ill?** If yes, please list all serious illnesses ____________________

☐ **Yes** ☐ **No** **Is your child allergic to anything?** If yes, please list ________________________________

☐ **Yes** ☐ **No** **Is your child taking any medications?** If yes, please list all medications ________________

☐ **Yes** ☐ **No** **Is there anything else we should know about your child?** If yes, please explain.

Parent or Legal Guardian Information

Parent/ Legal Guardian's Name ____

Telephone: Home ______________ Cell ______________ Work ________________

**** If legal guardian, see note below ****

To protect patient privacy, information about child's treatment can only be released to parents or legal guardians.
I do hereby give consent to the Florida Department of Health in Pinellas County, 205 Dr. Martin Luther King Jr. St. N. St. Petersburg, FL 33701, to use or disclose protected health information for treatment or Insurance/Medicaid payment. I agree if my child has urgent dental needs, his/her health information can be shared with the school nurse.
I understand that my child's medical information is confidential and the medical records are the property of the agency providing services to my child. The dental services at the school are funded by the Juvenile Welfare Board of Pinellas County (JWB) through local taxes. As part of the funding, the Florida Department of Health in Pinellas County is required to collect personally identifiable information including protected health information on my child. I agree and understand that confidential information, including but not limited to, protected health information pertaining to my child receiving treatment will be released to and received by JWB for the purpose of treatment, payment/reimbursement, quality improvements, research activities and compliance monitoring. I hereby release DOH – Pinellas and Juvenile Welfare Board, their employees, staff and representatives from all liability relating to or arising out of this release of information.
I understand this authorization is in place while my child is enrolled in the above mentioned school. This consent will terminate when my child is no longer enrolled in the above named school, except it will not apply to actions previously taken in reliance on this authorization such as ongoing research and compliance reviews with respect to information previously disclosed in reliance on this authorization. I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, it must be in writing and presented to my child's school and will not be effective with respect to actions previously taken in reliance on this authorization.

I hereby authorize DOH Pinellas to disclose my child's confidential information, including protected health information to Juvenile Welfare Board of Pinellas County as set forth herein.

Parent/Legal Guardian Signature ____________________________ **Date** __________

****Anyone other than a natural parent giving consent for treatment must provide legal documentation of guardianship.**
This program will be provided at your child's school. Your child may also be examined next year as part of our monitoring program. If you have any questions, please contact 727-773-5367.