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

Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

Florida Department of Health in Citrus County, Preventive Dental Program

Dear Parent/Legal Guardian: Teacher's Name: ___________________________

A preventive dental program will be coming to your child's school. This program is available at no cost to parents/guardians. Your child can receive dental screening / assessment, oral hygiene instructions, and sealants and fluoride varnish if needed. Services are provided by a licensed dental hygienist. No medications, shots, x-rays, or fillings will be given to your child. After receiving services, you will get a summary of the services your child received and any recommendations for follow-up care if needed. If you would like your child to receive these services, please complete, sign, and return this permission form to your child's teacher.

Child's Name: _______________________________ Date of Birth: __________________ Gender: ☐ M ☐ F

Street Address: ______________________________ City_________________________ Zip Code: _________

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

Select your child's dental insurance: ☐ Medicaid ☐ Florida Healthy Kids ☐ Other

Child's Medicaid number: ____

Florida Healthy Kids plan name and number: ____

Child's Health History:

☐ Yes ☐ No Is your child allergic to anything? List all allergies _______________________________________

☐ Yes ☐ No Is your child taking any medications? List all medications ______________________________

☐ Yes ☐ No Has your child been seriously ill? List all illnesses ____

☐ Yes ☐ No Has your child been to the dentist within the last year? Dentist's Name: ____________________

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

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Parent or Legal Guardian Information

Parent/Legal Guardian's Name: _____________________________ Date of Birth: _________________________

Telephone: Home: __________________ Cell: _____________________ Work: __________________________

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I certify that I have READ and UNDERSTAND the above questions and have answered them to the best of my knowledge. This dental care may include dental charting (screening / assessment), oral hygiene instructions, and sealants and fluoride varnish if needed. I understand that my child is not being provided other dental care that he/she may need. These services are not a substitute for a comprehensive dental examination. I authorize the Florida Department of Health and their dental providers to use or disclose protected health information for treatment or insurance / Medicaid payment purposes. I authorize the Florida Department of Health and their dental providers to receive payment from any insurance or any third-party payor that covers the services provided to this patient. By signing this form, I give permission for my child to participate in this program. If you have any questions, please contact our office at 352-513-6028.
06/2021-rg

Parent/Legal Guardian Signature ______________________________ **Date** ________________________