LICKING COUNTY HEALTH DEPARTMENT DENTAL SEALANT PROGRAM

Dear Parent/Guardian,

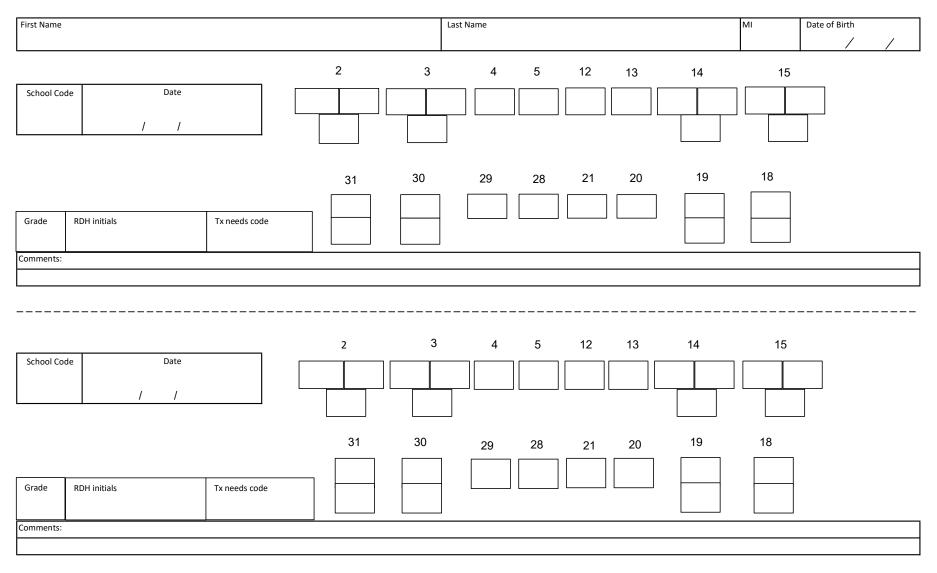
A <u>no-cost</u> dental program will be in your child's school. This program, which helps prevent tooth decay, is for second and sixth graders. A dental hygienist will screen your child's teeth and decide which teeth need to be sealed. The dental hygienist will then put the sealants on your child's teeth to seal out food and bacteria that cause decay. This is a two (2) year program, so your child's sealants will be checked <u>next year</u>; new sealants will then be applied if needed. Please fill out this form today. Your child must return it to their teacher. Thank you for your participation & consideration in this program!

PLEASE CHECK EITHER YES OR NO and RETURN.

YES, I want my child to receive SEALANTS. By signing below, I expressly give consent for my child to receive sealants and to participate in this two year program. I further acknowledge that I have received a copy of the applicable Privacy Practices. Please fill in the entire form, sign below and return form.

Signature	Date	e / /	
Child's Name:	Birth Date://	Male Female Child's Social Security Number:	
School:	Teacher:	Grade:	-
Home Phone Number:	Family Dentist Name:	Date of Last Dentist Visit:	_//
RACEPlease check all that apply for your child:AsianBlack or African AmericanWhiteNative American/Pacific Islander	□ Multiple Race □ Other	(production)	YES 🗆 NO
HEALTH HISTORY Does your child have any allergies to acrylic/plastic (e.g., latex)? (please check) 🗆 YES 🗆 NO			
Has your child ever had any serious health probl	ems? (please check) 🗆 YES 🗆 NO	If YES, please explain:	
No payment is required of you for this program. However your child is covered by Medicaid/Healthy Start, please Covered by Medicaid/Healthy Start, please Anthem	check the name of their Managed Care Plan a	Deer child and we rely on insurances such as Medicaid or Healthy Star and fill in the ID numbers. United Healthcare Corresource Medicaid # (12-Digits):	Humana Healthy Horizons ** in Ohio
NO, I do not want my child to receive SEALANTS. Please fill in child's name, sign below and return form.			
Child's Name:	Parent Signature:	Date://	
STOP HERE. Return form to your child's teacher.			
	C	Office Use Only	
Target DOS:/ Tooth #:			
Follow-Up DOS:// Tooth #:			Rev. 05/10/2022

LICKING COUNTY HEALTH DEPARTMENT PATIENT SEALANT RECORD



KEY

- NP Tooth Not Present
- FL Restored, Filled, Capped
- PE Partially Erupted
- **DE** Cavitated Carious Lesion
- **DE/NS** Carious Lesion/Needs Sealant

OS Old Sealant (previously applied by program)

NS Needs Sealant (to be applied)

- AO Partially Retained Sealant (add-on)
- XX Sealed Elsewhere (teeth were sealed by
 - personal dentist or another program)
- Lost Sealant (previously applied by program)
- **US** Unsealable (code only for smooth buccal pits and lingual grooves)

Treatment Needs Codes

- O = No obvious need for dental treatment
- 1 = Need for early dental treatment
- 2 = Need for immediate dental treatment