LICKING COUNTY HEALTH DEPARTMENT
DENTAL SEALANT PROGRAM

Dear Parent/Guardian,

A no-cost 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 next year; 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** ____/____/____

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:** ____/____/____

RACE Please check ***all that apply*** for your child: ☐ American Indian/Alaskan Native **ETHNICITY** Is your child Hispanic? (please check) ☐ YES ☐ NO

☐ Asian ☐ Black or African American ☐ Multiple Race

☐ White ☐ Native American/Pacific Islander ☐ Other _____

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 problems? (please check) ☐ YES ☐ NO If YES, please explain: _____

No payment is required of you for this program. However, the value of this service is more than $150 per child and we rely on insurances such as Medicaid or Healthy Start to help cover the costs. **If your child is covered by Medicaid/Healthy Start, please check the name of their Managed Care Plan and fill in the ID numbers.**

☐ Healthy Start Health Families ☐ Anthem ☐ MOLINA HEALTHCARE ☐ United Healthcare Community Plan ☐ CareSource ☐ Humana Healthy Horizons in Ohio

☐ buckeye health plan ☐ AmeriHealth Caritas Ohio

Managed Care ID: _____ **Medicaid # (12-Digits):** _____

☐ **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.

Office Use Only

Target DOS: ____/____/____ Tooth #: _____

Follow-Up DOS: ____/____/____ Tooth #: _____

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LICKING COUNTY HEALTH DEPARTMENT
PATIENT SEALANT RECORD

First Name	Last Name	MI	Date of Birth
			/ /

School Code	Date
	/ /

2 3 4 5 12 13 14 15

31 30 29 28 21 20 19 18

Grade	RDH initials	Tx needs code

Comments:

School Code	Date
	/ /

2 3 4 5 12 13 14 15

31 30 29 28 21 20 19 18

Grade	RDH initials	Tx needs code

Comments:

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)
LS 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

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