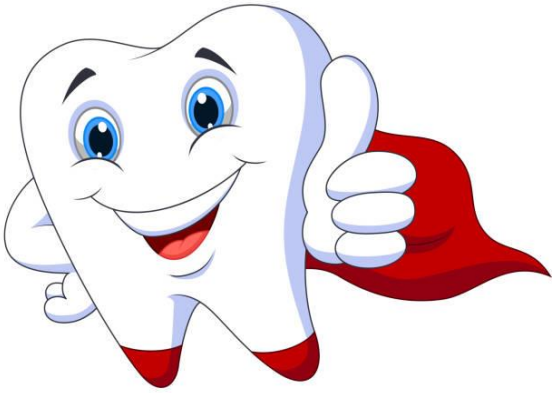
SEAL OUT CAVITIES... SEAL IN SMILES!

DENTAL SEALANTS

PROTECT YOUR CHILD'S TEETH FROM DECAY!

THE LICKING COUNTY HEALTH DEPARTMENT DENTAL SEALANT TEAM WILL BE AT YOUR CHILD'S SCHOOL SOON!

Our dental sealant program will be at your child's school sometime this school year to place sealants on the back molars of 2nd and 6th graders. **THERE IS NO COST TO PARENTS.**



WHAT ARE SEALANTS?

Sealants are thin, plastic coatings that keep food and germs out of the chewing surfaces of the back teeth and protect them from cavities. They are safe, easy to apply and there are no drills or needles involved. Sealants can also save you time and money on dental visits for fillings.

HOW CAN YOUR CHILD GET SEALANTS?

Your child can get sealants at no cost if you fill out the consent form in this online packet. Alternatively, you may fill out the paper consent form received from your school. Be sure to return that signed and completed form to your child's teacher. This is a TWO-YEAR program, so we will follow-up with your child in 3rd and 7th grades.

WANT MORE INFORMATION?

Please see the other documents in this packet for more info. You may also feel free to talk with your child's teacher, school nurse or call the Licking County Health Department Dental Program with any questions you may have.

LICKING COUNTY
HEALTH DEPARTMENT

Dear Parents/Guardians,

Our dental team will be coming to your child's school to apply dental sealants on their teeth. Dental sealants are a preventive measure with the intention of protecting your child's permanent molars from decay. They are quick, easy and are placed without the need to remove or destroy any of the existing tooth structure. There are also **no drills or needles** involved in the procedure. Both second and sixth grades are important years in permanent molar growth; therefore, all 2nd and 6th graders are eligible to sign up. We will follow-up with your child in 3rd and 7th grades to ensure their sealants remain functional and/or apply new ones. Please note that **there is no cost to you**, whether your child has a managed care plan, private insurance, or no insurance at all.

Please consider signing your child up for this program, as it is one of the most valuable ways to help prevent cavities and thus, potentially expensive restorative dental procedures. If your child has already received sealants, this can still be a benefit because additional teeth may have possibly erupted since they were initially placed. In addition, your child may benefit from having old or no longer effective sealants repaired and restored. Furthermore, sealants placed by our program do not interfere with the frequency of your child's preventive visits to their own dentist (exams, x-rays, fluoride, cleanings).

This sealant program, offered by the *Licking County Health Department* (LCHD), is funded by the *Ohio Department of Health* (ODH) and is **not affiliated with any mobile dentist your school might also use**. Our dental sealant team is comprised of a licensed dental hygienist and licensed expanded function dental auxiliary with a combined total of 25+ years of experience.

When you receive the gray consent form, **it is important to checkmark either "YES" or "NO", complete the form and return it to your child's teacher**. If you are reading this letter online, please fill out and submit the online consent form. We have included a list of frequently asked questions, should you have any additional concerns about the scope of our program. We are pleased to offer this program to your child's school and thank you for your consideration. If you have any additional questions, please call our program director, Kari Kennedy, at (740) 349-6492.

Stay Well,
LCHD Dental Sealant Team

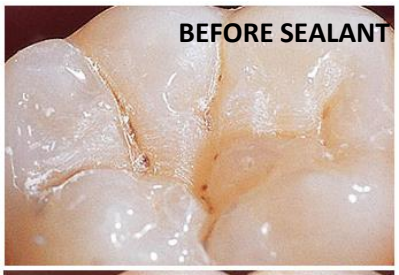
LICKING COUNTY
HEALTH DEPARTMENT

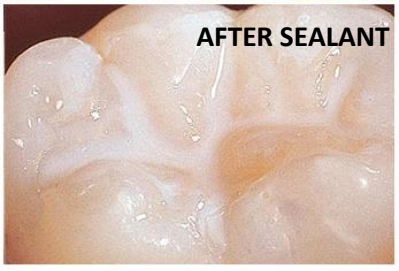
Dental Sealant Frequently Asked Questions (FAQ's)

1. **My child has an allergy to latex, plastics and/or acrylics, can they still get sealants?**
    a. Because our sealants are resin coatings, they are not intended for use in anyone with a known allergy to plastics and/or acrylics. We would be more than happy to still provide an exam for your child, but we *will not* place sealants on their teeth should they need them. Please be sure to properly checkmark the box indicating the allergy.
    b. Regarding latex allergies, there have been many advancements in the medical and dental fields over the years. All our disposable supplies are latex-free (i.e., gloves) and because our sealant material does not contain latex, your child may still have them placed.

2. **I'm concerned about infection control. How safe is placing sealants at school?**
    a. Our team has always, and will continue to, follow strict guidelines to stop the spread of germs. In addition to our resin-based sealant, our team has added a glass-ionomer sealant that does not require the use of aerosol-generating equipment (air/water spray). This sealant material is used during times of high community spread of COVID-19 and/or other communicable diseases.
    b. Many items used in placing sealants are disposable (used once and then thrown away), such as cotton rolls and paper bibs. Other items, such as mirrors, are used once, then sterilized in an autoclave. Additionally, while in schools, our team always uses a HEPA-filtered air purifier system.

3. **Can my child skip going to the dentist if they are getting sealants at school?**
    a. NO! Your child participating in this school-based sealant program *should not* replace any visit to their dentist! We recommend that your child visit their dentist at least once/year (twice/year is ideal) to have a full exam, cleaning and any necessary work done. Remember, PREVENTION IS KEY!





4. **If my child has a cavity, will placing a sealant over it treat it?**
    a. Simply put, *no*. Sealants are only placed on teeth free from decay. If, during our exam, it is found that your child possibly has cavities, you will be notified in the letter we send home with them. It is very crucial that you schedule an appointment for them to have a proper evaluation by their dentist to address the possibility of decay. The goal is to stop the decay while it is small and least-costly. Please see your school nurse if you need assistance in obtaining dental care for your child.

5. **My child recently received sealants. Is it normal for their bite to feel off?**
    a. Yes, this is a normal feeling. Because the sealant material sits on the surface of the tooth, the tooth may feel a bit tall when your child bites down initially. We use a self-adjusting sealant, meaning that after a few days of normal wear (chewing, talking, etc.), the sealant will adjust itself.

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!

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.**

Parent/Guardian 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 Hawaiian/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 ☐ Anthem ☐ MOLINA HEALTHCARE ☐ United Healthcare Community Plan ☐ CareSource ☐ Humana Healthy Horizons in Ohio

☐ buckeye health plan ☐ AmeriHealth Caritas Ohio

Plan ID #: _____ **Member ID #:** _____

☐ **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/Guardian Signature:** _____ **Date:** ____/____/_____

STOP HERE. Return form to your child's teacher.

Office Use Only

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

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

Rev. 06/05/2023

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

Rev. 06/06/2023

LICKING COUNTY
HEALTH DEPARTMENT

Notice of Privacy Practices Summary
Effective October 1, 2013

Who Will Follow These Practices?

The Licking County Health Department provides health care to our patients and clients in partnership with physicians and other professionals and organizations. The information privacy practices in this information sheet will be followed by:

- Any healthcare professional from the Licking County Health Department
- All divisions of the Licking County Health Department
- All employed staff or volunteers of the Licking County Health Department
- Any associate or partner of the Licking County Health Department with whom we share health information.

Your Medical Information is Personal

We understand that your medical information is personal; and we are committed to protecting it. To provide quality care and to comply with legal requirements, we create a record (chart) of the care and services you receive from our staff. These privacy practices apply to all your records of care that we maintain, whether created by our staff or your personal physician. By law we are required to:

- Keep medical information about you private
- Give you this notice of our legal duties and privacy practices with respect to medical information we have obtained about you
- Follow the terms of the privacy practices currently in effect

Changes in the Privacy Policy

We may change our privacy policies at any time. Changes will be posted in a prominent place in our facility or satellite site before any significant ones are made. You have the right to a paper copy of this policy. You may request a copy of our most current policy at any time. The effective date is listed above, just below the title. You will be offered a copy or our privacy policy when you are first admitted to our facility or clinic site for medical services. At that time, you will be asked to acknowledge in writing your receipt of this notice.

Use and Disclosure of Your Medical Information

We may use or disclose medical information about you if you are referred elsewhere for treatment, such as sending medical information about you to a specialist as part of your referral. Your information may be sent when billing your insurance company or Medicare to obtain payment for treatment. We may also use information about you to support our health care operations by comparing patient data to improve treatment methods.

In addition, we may use or disclose medical information about you, without your prior authorization, for other reasons. Subject to certain requirements, we may give out your medical information for the following reasons:

- Public health purposes such as community health surveillance, investigation and tracking
- Abuse or neglect reporting
- Health oversight audits or inspections
- Research studies
- Funeral arrangements and organ donation
- Workers' compensation purposes
- Emergencies

We also disclose medical information when required by law. For example, we must respond to request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders. We may also contact you to remind you of an appointment or to tell you about possible treatment options, alternatives, health-related benefits or services that my interest you. We may disclose your medical information to a friend or family member who is involved in your medical care. To assure that your family can be notified of your location and condition in case of an emergency, your information may be given to disaster relief authorities.

Other Uses of Medical Information

We will ask you for your written authorization to disclose medical information about you in any situation not covered by this agreement.

OVER

If you choose to authorize use or disclosure, but change your mind later, you can revoke your authorization by notifying us in writing of your decision.

Your Rights Regarding Your Medical Information

In most cases, if you submit a request in writing, you have the right to see, or get a copy of your medical information that we use to make decisions about your care. A nominal fee may be charged for the cost of copying and mailing the information to you. If we deny your request to review, or obtain a copy, you may submit a written request for a review of that decision. If you believe that information in your record is incorrect, or that important information is missing, you have the right to requisition request that we correct the records. You will need to submit your request in writing and give your reason for requesting the change.

We can deny your request to amend a record if the information was not created by us; if it is not part of the medical information maintained by us; or if we determine that a record is accurate. You may appeal, in writing, our decision not to amend the record.

Other than for treatment, payment, health care operations or where you, in writing, authorized a disclosure, you have the right to list of those instances where we have disclosed medical information about you. In your request you must state the time period desired, which must start after February 1, 2005 and be less than a 6-year period. The first disclosure list requested in a 12- month period is free; other request will be charged according to our costs of producing the list. We will inform you of the cost before providing the list to you.

You have the right to request that medical information be communicated to you in a confidential manner. You may notify us in writing how you wish us to communicate with you, i.e., requesting that we send your mail to an address other than your home.

You may request, in writing, that we not use or disclose medical information about you for treatment, payment of healthcare operations, or to persons involved in your care except when specifically authorized by you, when it is required by law, or in an emergency. Your request will be considered; however, we are not legally required to accept it. We will inform you of our decision on your request. It is your right to appeal our decision, in writing, to our Director of Nursing or Health Commissioner.

If your protected health information was disclosed to an unauthorized person, you will be notified in writing.

Director of Community & Personal Health
Kari Kennedy B.S.N., M.B.A., R.N.
kkennedy@lickingcohealth.org

Health Commissioner
Chad Brown, MPH, REHS
cbrown@lickingcohealth.org

Licking County Health Department
675 Price Road
Newark, Ohio 43055

Phone: 740-349-6535
Fax: 740-349-6510

If you have any questions regarding this information sheet, please contact the Director of Nursing or the Health Commissioner listed above.

Finally, if you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may send a written complaint to the following:

Office of Civil Rights
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: 1-877-696-6775

Under no circumstance will you be penalized or retaliated against for filing a complaint. Please be aware that mail sent to the Washington D.C. area office takes an additional 3-4 working days to process due to changes in mail handling results from Anthrax crisis of October 2001.

This information sheet has been provided to explain how medical information that we gather about you may be used and disclosed. It also explains how you can access your medical information.