Florida Department of Health in Pasco County
Dental Bus Sealant Oral Health Program – No Cost To Parent

Second, Third, Fourth & Fifth Grade students receive dental assessment, dental sealants, fluoride varnish.
Sixth, Seventh & Eight Grade students receive dental assessment, dental sealants, fluoride varnish.

Your child will receive a free toothbrush, toothpaste and floss.

School Name ____________________ Teacher ____________________ Grade __________

Print Child's Name ______________________________ Date of Birth ______________

Street Address ______________________________________ Zip Code __________

Race/Ethnicity ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/ Native ☐ Hispanic ☐ Other

Sex ☐ Male ☐ Female / My child has a dentist: ☐ Yes ☐ No Name of dentist ______________

Child's Health History

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

☐ Yes ☐ No Has your child been seriously ill? If yes, please explain ____________________

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

☐ Yes ☐ No Is your child taking any medications? If yes, please list ____________________

My signature below indicates consent for my child to receive the above services, and also is my consent to the sections marked "Initiation of Services" by the Florida Department of Health, the reverse side of this document, and "Hold Harmless, Indemnification, and Release Agreement" for the Pasco County Schools, the reverse side of this document.

I certify that I have READ and UNDERSTAND the above questions, have answered the questions to the best of my knowledge, and have had all my questions answered. I understand that my child is not being provided other dental care that s/he may need. I understand that this Outreach Program will be provided by Florida Department of Health in Pasco County Dental Program at my child's school. On behalf of myself and/or the patient, I authorize the dental providers to receive payment from any insurance or any third party payor that covers the services provided to this patient. I understand there is no out-of-pocket expense to me for these services for any child.

RETURN FORM TO YOUR SCHOOL WITH EITHER "YES" OR "NO" FOR DENTAL BUS PROGRAM.

Check Box ☐ Yes ☐ No I CONSENT TO MY CHILD'S PARTICIPATION IN THIS PROGRAM.

Parent or Legal Guardian Information

Print Parent/Guardian's Name ______________________________ Phone No ______________

Parent/Guardian's Signature ______________________________ Date ______________

Initiation of Services

Part 1 CLIENT-PROVIDER RELATIONSHIP CONSENT
Client Name: **ON REVERSE SIDE**
Name of Agency: Florida Department of Health in Pasco County
Agency Address: 10841 Little Road New Port Richey FL 32654
I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand rountine health care is confidential and voluntary and may involve medical office visits including obtaining medical history, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue the relationship at any time. I may withdraw my consent at any time by a written withdrawal given to the Provider.
PART II DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only) I consent to the use and disclosure of my medical information, including medical, dental, HIV/AIDS, STD,TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.
PART III ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers) As Client/Representative signed on reverse side of this page, I assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency.

Your signature at the bottom on the reverse side serves as consent to this section.

Pasco County Schools

Kurt S. Browning, Superintendent of Schools
7227 Land O' Lakes Boulevard • Land O' Lakes, Florida 34638

HOLD HARMLESS, INDEMNIFICATION, AND RELEASE AGREEMENT

This agreement is a waiver, release, indemnification agreement, and hold harmless, which acts to release the District School Board of Pasco County, its individual members, schools, personnel, employees, agents and assigns (hereinafter collectively referred to as School Board) from any and all judgments, attorney fees, costs, payments, medical bills, damages, claims, suits or other expenses which may result from the use of School Board property by The Florida Department of Health in Pasco County, (hereinafter DOH-Pasco) for the purposes of providing dental health services. Parent/guardian agrees to release and hold the School Board harmless for any injuries, damages, suits or claims, arising out of this matter, regardless of whether such injuries or damages arise out of the accidental, negligent or reckless acts of DOH-Pasco or School Board, its employees, subcontractors, agents and assigns. Parent/guardian understands that, for the purposes of this agreement, participation in the event, and the protections afforded to the School Board by this agreement, not only extends to and includes the service provided but also encompasses any other acts while on School Board property that are directly or indirectly related to the event.

Your signature at the bottom on the reverse side serves as consent to this section.