

# Fluoride Varnish Program Parent/Guardian Consent



Dear Parent/Guardian:

A preventive dental program is available for your child. Two times during the school year, a licensed dental hygienist will provide a free basic dental screening and apply a protective coating called fluoride varnish to your child's teeth as a preventive measure against tooth decay.

To receive these **no-cost** services, you must provide consent.

*By signing this form, I agree that I want my child to receive a fluoride varnish and a basic dental screening.*

## Child's Information

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: \_\_\_ Male \_\_\_ Female Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

## Dental Insurance Information

In order to continue providing valuable preventive services at **no-cost** to your family, we ask that you provide your child's dental insurance information so the dental hygienist may submit and accept fees for services rendered. This will help offset the cost of the fluoride varnish and dental supplies.

Medicaid State ID: \_\_\_\_\_ CHP+ Member ID: \_\_\_\_\_

Name of Dental Insurance: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_

Subscriber's Phone Number: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_

Subscriber's Date of Birth (mm/dd/yyyy): \_\_\_\_\_

I understand that fluoride varnish helps to protect teeth from cavities. After receiving a fluoride varnish application, it is acceptable for my child to drink cool liquids and eat soft foods right away. For the treatment to be most effective, I have been advised to avoid serving my child hard, crunchy foods for 2 hours, and to wait a minimum of 6 hours or until the next morning to resume brushing and flossing.

Parent/Guardian Signature : \_\_\_\_\_ Date: \_\_\_\_\_

(This consent will be valid for the entire school year)

### FOR OFFICE USE ONLY

Varnish placed on: \_\_\_\_\_ and/or \_\_\_\_\_ by: \_\_\_\_\_

0- Routine

1- Early Dental Needs

2-Urgent Dental Needs

0- Routine

1- Early Dental Needs

2-Urgent Dental Needs

Comments: \_\_\_\_\_

*\*\*\*This service does not replace a comprehensive evaluation. It is our recommendation that a dentist examine your child twice each year. \*\*\**