



FREE DENTAL FLUORIDE VARNISH PROGRAM

A free dental fluoride varnish program, designed to help prevent tooth decay, will be starting at your child's daycare/preschool. Fluoride Varnish is a very effective topical fluoride that is painted on the teeth, hardens on contact with natural saliva in the mouth and is slowly released over a 24-hour period. It is well tolerated by kids since it has a very mild flavor and is applied in a small amount. A Registered Dental Hygienist will be applying fluoride approximately every 3-4 months. Please fill in this form today and return to your daycare/preschool provider within 3 days. This is not intended to replace your regular exams at your dental office.

YES. I want my child to receive FREE dental screenings & fluoride varnish treatments.

NO. I do not want my child to receive dental screenings & fluoride varnish treatments.

Name of Child _____

Date of Birth ____/____/____ [] Male [] Female Home # _____ Cell # _____

School _____ Teacher _____ Grade _____

Home Address _____ City _____ Zip _____

Race/Ethnicity (Check all that apply):

- [] White [] Black/African American [] Hispanic [] Asian [] American Indian/Alaskan Native [] Pacific Islander

Brief Health History

- 1. Is your child currently under a physician's care? Yes / No
2. Is your child currently taking any medications? Yes / No
3. Has your child ever had any allergic reactions to dyes, foods or medications? Yes / No
Please explain any YES answers: _____
4. Do you have a regular family dentist? Yes / No Name: _____
5. My child's most recent dental visit was with the last: [] 6 months [] 12 months [] 3 years [] 5 years [] Never seen a dentist
6. How do you pay for your child's dental care? [] Self [] Medicaid/Title 19 [] hawk-i [] Private dental insurance [] Other
7. List any problems now or recently with your child's teeth. _____
8. Do you or anyone in the home have cavities now? Yes/No
9. How many times does your child eat snack foods, or sugary, sticky foods or drinks each day? _____
10. Does your child carry something around to drink (other than water) at home? Yes/No
11. Does your child drink fluoridated water, take fluoride supplements or use toothpaste with fluoride in it? Yes/No
12. Does your child brush at least 2 times a day and floss regularly? Yes/No
13. Do you help your child (under 8 years old) brush and floss? Yes/No
14. Who is your child's doctor? Name: _____
15. Can your child see this doctor for check-ups and sickness? Yes/No Date of last visit: _____
16. Does your child have medical insurance? [] Self [] Medicaid/T19 [] hawk-i [] Private medical insurance [] Other
17. Is your child eligible for free/reduced cost lunch program at school? Yes/No
18. Would you like information mailed to you about the hawk-i insurance program? Yes/No
19. Is your child up to date on their immunizations? [] Yes [] No [] Unknown

- I understand that these services are provided under the Iowa Department of Public Health (IDPH), Maternal and Child Health Program.
I understand records created and maintained as part of this program are the property of IDPH and may be shared with IDPH, Iowa Department of Human Services (DHS), dentists or designee.
I understand records are available to the DHS for auditing purposes.
I understand that consent for treatment is valid for one year from date of signature below.

Office Use Only: Health History reviewed: _____



PARENT OR GUARDIAN _____ Date ____/____/____ (sign)

Please print parent/guardian name _____