

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. The program will include all ages of children. **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.

Sheila Temple, a Registered Dental Hygienist with Washington & Henry County Dental Programs, will be applying fluoride approximately every 3-4 months; but this form only needs to be signed once per child per year by the parent/guardian. Please fill in this form today and return to your daycare/preschool provider.

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 ____/____/____

Medicaid # (if have) _____ Male Female Race _____

School/Daycare _____ Teacher/Provider _____

Home Address _____ City _____ Zip _____ Contact Phone _____

- Do you have a regular family dentist? **Yes** **No** If yes, whom? _____
- Does your child see the dentist at least once per year? **Yes** **No**
- My child's most recent dental visit was within the last: (please check one) 6 months 12 months
 3years 5 years Has never seen a dentist
- How do you pay for your child's dental care? (Please check one) Self Medicaid/Title XIX
 Hawki Private dental insurance Other
- Do you have a regular family doctor? **Yes** **No** If yes, whom? _____
- How do you pay for your child's Medical care? (Please check one) Self Medicaid/Title XIX
 Hawki Private insurance Other

HEALTH HISTORY

- | | | |
|--|--|----------------------------|
| | | Reviewed (office use only) |
| 1. Has your child ever had any allergic reactions? | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| 2. Is your child currently under a physician's care? | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |
| 3. Is your child currently taking any medications? | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ |

Please explain any Yes answers: _____

- I understand that these services are provided under the Iowa Department of Public Health, Maternal and Child Health Program.
- I understand records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health, Bureaus of Family Health or Oral Health or designee.
- I understand records are available to the Department of Human Services for auditing purposes.



No payment is required from you for this Program.

PARENT OR GUARDIAN _____ Date ____/____/____

(sign)

Please print parent/guardian name also _____