Dental Health Consent Form

_____ **Yes,** I would like my child to participate in the tooth-brushing program, fluoride varnish and the oral screening programs at my child's day care ***free of charge regardless of insurance status.***

_____ **No**, I do not want my child/children to participate in any of these programs

The Center for Disease Control and Prevention recommends that all children brush their teeth with toothpaste containing fluoride, receive an annual oral screening exam, and receive a fluoride varnish, applied topically, at minimum of once year.

Child's Name:	**Date of Birth:** **___/____/____**	**Dentist/Dental Provider:**
Address:	**Child's Sex:** **Male Female**	**Parent/Guardian Name:** **Phone Number:**
Current Medications:	**Allergies?**	**Any current medical concerns or problems?**
Perscription Fluoride? **Yes No**	**Insurance:** ☐ **Medicaid #_____** ☐ **Private** ☐ **None** ☐ **Other_____**	**Any dental concerns or problems**

As the parent/guardian, I hereby give consent for my child to receive a dental screening, fluoride varnish treatment and participate in the toothbrushing program at my child's day care. By signing this form, I am also acknowledging that a copy of the **Notice of Privacy Practices** has been given to me or made available to me.

Parent's/Guardian's name and Phone number:

_____

Signature:

_____

Date:

_____

Comments:

_____

Should you have any questions about any of these programs, please do not hesitate to contact your site administrator. Thank you for choosing us.