Reach Dane
Early Head Start
Childcare Program

A Fluoride Connection
Non-Profit Corporation
Kathleen A Traut, RDH
Executive Director
Child Health Care Provider
Keeping Teeth Healthy One Child at a Time

HEALTH HISTORY/PERMISSION SLIP

Child's Name: _____

Classroom: _____

I fully understand the information provided about fluoride varnish. I hereby give my consent for the fluoride varnish program to apply fluoride varnish on my child's teeth as I have indicated below. The treatment your child will receive in this program is not meant to be an alternative to regular dental care. It is still strongly recommended that you seek out a dental home (family dentist) for routine dental care including any follow up care which may be recommended after your child has completed this school based oral health program. This consent is valid for one year from the date of signature below.

☐ **Yes, I want my child to have fluoride varnish application.**

☐ **No, I do not want my child to have fluoride varnish application.**
If no, visual exam okay: ☐ Yes ☐ No

Please complete the following:

Child's Last Name_____First Name_____DOB_____

Address_____City_____State_____Zip_____

Phone_____Child's Gender: ☐ Male ☐ Female

Child's Race/Ethnicity: ☐ White ☐ Hispanic ☐ Asian ☐ American Indian/Alaska Native
☐ Black/African American ☐ Bi-Racial ☐ Multi-Racial ☐ Other

1. Does your child see a dentist regularly? ☐ YES ☐ NO If yes, please list dentist_____
2. Is your child in any other fluoride varnish program? ☐ YES ☐ NO
3. Does your child have any allergies? (i.e., medications, food, latex, etc.) ☐ YES ☐ NO
   If yes what type? _____
4. Has your child been diagnosed with any chronic heart condition? ☐ YES ☐ NO
   If yes, please list_____
5. Is your child on any medications prescribed by a doctor? ☐ YES ☐ NO ****If yes, please list medications here**_____
6. Do you give permission for your child to be photographed during the program? ☐ YES ☐ NO
7. Is your child covered by private dental insurance? ☐ YES ☐ NO
8. Is your child covered by Medical Assistance, Badger Care, or Forward Health? ☐ YES ☐ NO If yes, please list I.D.#_____
   (This program will be billing the state of Wisconsin for services-You will not pay any co pays or deductibles for this program).

_____ _____ _____
SIGNATURE-Parent or Guardian | Print Parent or Guardian Name | Date Signed