Reach Dane
Infant & Toddler
Child Care Program

White-Administration
Yellow-Dental Hygienist
Pink-Parent

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 you 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 date of signature below.

______Yes, I want my child to have fluoride varnish application.

Please sign below & return to school.

Please complete the following:

Child's Last Name_________________First Name_________________________DOB_____________

Address____________________________City___________________State_________Zip__________

Phone_______________Child's Gender: M F Child's Race/Ethnicity: WHITE HISPANIC ASIAN
AMERICAN INDIAN/ALASKA NATIVE
BLACK/AFRICAN AMERICAN
BI-RACIAL(2) MULTI-RACE(3) 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 conditions? 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