Place Health Department
OR Program Logo Here

Kids Smile Fluoride Varnish Program

Dear Parent or Legal Guardian,

A dental screening and fluoride varnish program will be coming to your child's school. Fluoride varnish helps prevent cavities. It is painted on and can be applied up to 6 times a year. This is a safe and easy way to help your child stay healthy. The _____ County/District Health Department's Public Health Registered Dental Hygienist (PHRDH) will screen your child's teeth and determine the need for fluoride varnish. Once fluoride varnish is applied, if dental needs are noted, a referral to the dentist will be made.

Please Provide All Information Requested on Form

___ YES, I DO WANT my child to receive a dental screening and fluoride varnish

___ NO, I DO NOT WANT my child to receive this service

Child's Name: L_____ MI___ F_____ Gender (please circle): Male Female Race:_____

Child's Date of Birth: ___/___/____ Child's Social Security Number:_____

Parent/Legal Guardian: L_____ MI___ F_____

Address:_____ Phone:_____ Email:_____

City:_____ Zip Code:_____ School:_____ Grade:___ Teacher:_____

MEDICAL INFORMATION

Does your child have any allergies to latex, foods, pine nuts or medicines? YES or NO **If yes, please list**:_____

Doe your child have any illnesses, diseases, or conditions including (but not limited to) ADHD, ADD, Asthma, Heart Conditions, Diabetes? Yes or No **If yes, please list**: _____

List any medications and dosage your child takes daily:_____

Dentist Name:_____ Does your child have private dental insurance (circle)? YES NO

Does your child have Medicaid (circle)? YES NO Medicaid Number:_____ MCO Number:_____

MCO (please circle): Molina United Healthcare Passport Anthem Aetna Well Care Humana

CONSENT FOR DENTAL SERVICES: Of my own free will, I consent to care for my child which may include a dental screening and fluoride varnish application provided by staff or agents of this health department. I understand that no guarantees are being made as to the effect of any preventive service provided for my child. I also understand that no X-Rays will be done. This form, when completed and signed, contains protected health information which will be protected according to the Health Insurance Portability and Accountability Act (HIPAA). My signature below acknowledges my receipt of _____County Health Department (__HD) "***NOTICE OF PRIVACY PRACTICES"*** on the date stated. I understand that no dentist is present for the dental services provided. The PHRDH is working under the programmatic supervision of the Department for Public Health's State Dental Director, Dr. Julie Watts McKee.
Assignment of Benefits: I request that payment of authorized insurance benefits be made to ___HD on my child's behalf for services received. I also authorize ___HD to release oral health information about my child to Medicare, Medicaid, Private Insurance and other third-party payers to determine payment for services.

This service will be provided during the instructional day.

_____ Date:_____

Parent/Legal Guardian Signature **(expires end of current school year)**