

**SMILES ON WHEELS  
Fluoride Varnish Program**

**Varnish! Michigan  
PARENT CONSENT FORM**

CHILD AGE \_\_\_\_\_

Child's First Name \_\_\_\_\_ Child's Middle Name \_\_\_\_\_ Child's Last Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Date of Birth: Month/Day/Year \_\_\_\_/\_\_\_\_/\_\_\_\_ M \_\_\_\_ F \_\_\_\_ Child's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (confidential)

Which of the following describes your child? (Check one or more)  
 Black/African American     White     Hispanic/Latino     Asian  
 American Indian/ Alaskan     Native Hawaiian/Other Pac. Islander     Arab American  
 Other

Tooth decay is one of the most common diseases found in children. Fluoride varnish can be painted on teeth to protect teeth from cavities. Fluoride varnish can be applied up to 4 times a year.

**This consent will be valid for the 12 month period of this program.**

YES, I give my permission for my child to receive : \_\_\_\_\_ Site name: \_\_\_\_\_  
 Fluoride Varnish, Oral Screening and Dental Cleaning if necessary

NO, I do not give my permission for my child to receive \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Fluoride Varnish or Oral Screening

Printed Parent Name \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

Parent or Guardian Email address \_\_\_\_\_

Smiles on Wheels have my permission to use photos of my child for educational or promotional purposes.  Yes  No

**HEALTH HISTORY:**

1. Is your child allergic to anything?  YES  NO If yes, what? \_\_\_\_\_
2. Is your child allergic to pine sap? (Fluoride varnish can contain a small amount of pine sap.)  YES  NO
3. Is your child taking any medications?  YES  NO If yes, what? \_\_\_\_\_
4. Does your child have any medical conditions such as heart disease, asthma, hay fever, hepatitis, cancer, Diabetes, etc.? Other conditions?  YES  NO If yes, what? \_\_\_\_\_

No payment is required from you for this program. However, Medicaid/Healthy Kids Dental/MI Child and other dental insurance carriers help cover the cost of this program. Please fill out insurance information. If NO insurance would you like Michigan Primary Care Association assistances in enrollment for insurance?  YES  NO

Medicaid #: \_\_\_\_\_ Healthy Kids #: \_\_\_\_\_

Other Insurance#: \_\_\_\_\_ Insured Name \_\_\_\_\_

Insured Date of Birth \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Insured SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Insured Employer \_\_\_\_\_ Phone # \_\_\_\_\_

**Questions about the Program? Contact: Smiles on Wheels 517-740-5620 or email: [smilesonwheels@hotmail.com](mailto:smilesonwheels@hotmail.com)**

Office use only Date \_\_\_\_\_ Tb prophylaxis \_\_\_\_\_ Varnish \_\_\_\_\_ # teeth \_\_\_\_\_ Fills \_\_\_\_\_ Cavities \_\_\_\_\_ White spots \_\_\_\_\_ RDH \_\_\_\_\_ INSPD \_\_\_\_\_