

Fluoride Varnish and Prevention 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 :

Event Site: _____

Fluoride Varnish, Oral Screening, Dental Cleaning and Sealants if necessary.

NO, I do not give my permission for my child to receive

Event 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.? Or any other medical condition? 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 517-740-7422 or email: smilesonwheels@hotmailcom

Office use: Date ____ RDH ____ Tb prophyl ____ Varnish ____ # teeth ____ Fills ____ Cavities ____ White spots ____ INSPD ____