Price County
Health & Human Services

Healthy People in Safe and Vibrant Communities

Early Childhood Cavity Prevention Program

Fluoride Varnish Program

Child's Last Name _____ Child's First Name _____ DOB_____
(MM/DD/YYYY)

Male_____ Female _____

I understand that fluoride varnish helps to protect teeth from cavities. Fluoride varnish may be applied to my child's teeth up to four times per year. After fluoride varnish application, I should not give my child crunchy, sticky, or hot foods for one day. Your child will not need to brush for six (6) hours after the application. The oral screening your child receives does **not** take the place of a complete dental examination by a dentist. You will receive a follow up paper after the oral screening and fluoride varnish has been applied.

☐ **Yes, I give permission for my child to participate in the Price County Public Health Early Childhood Cavity Prevention Program.**

If *YES*, please answer the following questions:

1. Does your home use water from your own well? YES_____ NO_____
2. Is your home presently connected to a community water supply? YES_____ NO_____
3. Does your child take fluoride supplements? YES_____ NO_____
4. Does your child see a dentist regularly? YES_____ NO_____
5. Has your child seen the dentist within the past year? YES_____ NO_____
   DENTIST NAME: _____
6. Does your child have an allergy to any of the following?
   Pine/Evergreen Tree Sap? YES_____ NO_____
7. Does your child have special health care needs? YES_____ NO_____
8. Does either parent/guardian use tobacco products? YES_____ NO_____
9. Do you have Medicaid/Badger Care? YES_____ NO_____
   If you have MA/Badger Care, what is your *child's* **10-digit number?** _____
10. I give Price County Public Health permission to bill *Medicaid/Badger Care* for the services provided: YES_____ NO_____
11. Race: White_____ Black/African American_____ Asian_____ American Indian/Alaska_____ Native_____ Pacific Islander/Hawaiian_____ Other_____
12. Ethnicity: Hispanic or Latino_____ Non-Hispanic_____ Unknown_____

☐ **No, I do not give my permission for my child to participate in the Early Childhood Cavity Prevention Program.**

Please Fill Out the Following Regardless of "Yes" or "No" Response- Thank You!

School Name: _____ Teacher Name: _____

Child's Grade: _____ Parent or Guardian Email: _____

Home and/or Cell Phone Number of Parent or Guardian: _____

Printed Parent or Guardian Name: _____

Signature of Parent or Guardian: _____ Date Signed: _____

Price County Public Health has included information for you on the confidentiality of your medical records under the federal privacy law (HIPPA). Please see the attached.

104 South Eyder Avenue, PO Box 88 Phillips, WI 54555-0088
Phone: 715-339-3054 Fax: 715-339-4018 Email: hhsd@co.price.wi.us

Revised 06.2019