Fall Varnish Date: _____

Spring Varnish Date:_____

Dear Parent or Guardian:

A preventive oral health program is available through the Missouri Department of Health and Senior Services, Macon County Health Department and _____School. This program is offered to **all** children in the state of Missouri, including those who receive regular dental care.

A licensed dental professional will provide an oral screening for your child and a trained volunteer will apply a thin coating of fluoride varnish to your child's teeth as a preventive measure against tooth decay. This thin coating of fluoride varnish will be applied **twice** during the school year. Fluoride varnish has been proven to be safe and effective in preventing and reversing small areas of early tooth decay. This preventive program also includes a free toothbrush and oral health information.

*** This service does not replace a regular dental check-up, which is recommended at least once a year. ***

To receive this **no cost** screening and fluoride varnish application, you must provide consent.

_____ **Yes**, I want my child to receive a dental screening and **two** applications of fluoride varnish, approximately three to six-months apart.

_____ **Yes**, I want my child to have the dental screening, but I do not want my child to have the fluoride varnish.

_____ **No**, I do not want my child to participate in this program.

Child's Name: _____ Age: _____

Teacher: _____ Grade: _____

Health History

Has your child ever had serious health problems? Yes: ___ No: ___ If yes, please explain:

_____

Does your child have any allergies? Yes: ____ No: ____ If yes, please list:

_____

Parent/Guardian Signature: _____Date_____

This institution is an equal opportunity provider

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