San Joaquin County Public Health Services
health grows here

Fluoride Varnish Program

Parent - Authorization and Referral Form

Student Information (Filled out by parent/guardian)

Name: _____, _____ _____ Date of Birth: ____/____/_____
(Last Name) (First Name) (M.I.) MM DD YYYY

School Name: _____ Teacher: _____ Grade: _____

Race/Ethnicity: ☐Asian/Pacific Islander ☐ Black/African American ☐ Hispanic/Latino ☐ White
☐ Multi-racial ☐ Native American ☐Unknown ☐ Other (*Please specify*): _____

Has your child ever had:

1. **Allergies?** ☐ YES ☐ NO *If yes, to what:* _____
2. **Any health problems?** ☐ YES ☐ NO *If yes, please explain:* _____

Is your child currently under the regular care of a dentist? ☐ YES ☐ NO

If yes, what is the dentist's name?: _____

When was the last time your child saw a dentist? ☐ Less than 6 months ago
☐ Between 6 and 12 months ago
☐ More than 12 months ago

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment, or dental screening and fluoride varnish. I understand this screening is only a very basic evaluation and does not take the place of a thorough dental examination. I would need to secure the services of a dentist in order for my child to receive a complete dental examination necessary to establish and maintain good oral health. I also understand that receiving this dental screening does not establish any new, ongoing, or continuing doctor patient relationship. I am free to establish such a doctor-patient relationship for my child in the future with the dentist of my choice. Further, I will not hold those performing this screening responsible for the oral health consequences or results should I choose NOT to follow the recommendations listed below. I also understand that the information in this assessment is confidential. Your child's information will ONLY be shared with the Oral Health Program (OHP) or one of its program partners, who will contact me if dental problems are identified to provide dental care coordination.

Please **check** the appropriate box below & **sign** for your child to receive dental services:

☐ **Yes, I give permission for my child to participate in the fluoride varnish program and receive fluoride varnish treatment once a year.**

☐ **No, I do not wish for my child to receive a dental screening and fluoride varnish.**

Parent/Guardian Name (Print): _____ **Phone:** _____

Parent/Guardian Signature: _____ **Date:**_____

For Administrative Use Only (Do not mark below this line)

Results (select one)	Varnish applied on : _____/____/_____ MM DD YYYY
☐ No Visible Decay Present ☐ Early Dental Care Needed (visible decay, fillings and/or white spots) ☐ Urgent Dental Care Needed	Varnish applied by (Name & Title): _____

If fluoride varnish was not applied, why not?

☐ Pulp exposure ☐ Tissue lesions ☐ Child uncooperative ☐ Other: _____