Dear Parent or Guardian:

Our school and the Missouri Department of Health and Senior Services, Office of Dental Health are offering a **FREE** oral health program to help prevent cavities. This program is offered to **ALL** children in Missouri, including those who visit a dentist every year. A person who has been trained will see your child and will wear gloves and use a disposable mouth mirror. **With consent** fluoride varnish will be applied to your child's teeth to help stop cavities. Fluoride varnish is safe for use in preventing and reversing small areas of early cavities and will be applied two times during the school year. The data from the oral health review is collected by the Office of Dental Health to better understand oral health needs of Missouri children.

Children participating will receive a free age-appropriate toothbrush, toothpaste, and information on oral health.

This service does not replace a regular dental check-up. It is recommended to visit a dentist at least once a year.

PARENT/GUARDIAN PLEASE COMPLETE AND SIGN THE FOLLOWING SECTION

There is **no cost, and insurance will not be billed** for the oral health review and fluoride varnish treatments, but you must give your consent.

☐**YES,** I want my child to receive an oral health review and two applications of fluoride varnish, 3 to 6 months apart.

☐**YES**, I want my child to receive an oral health review. I do not want my child to have the fluoride varnish.

☐**NO**, I do not want my child to take part in this oral health program.

Child's Name: _____**Age:** _____ **Grade**: _____ **Teacher:** _____

Mark "ALL" that apply for Race:	**Mark "ONE" that applies for Ethnicity:**	**Mark "ONE" that applies for your child's dental insurance (data purposes only):**
☐ American Indian/Alaskan Native	☐ Hispanic	☐ Medicaid/Missouri Managed Care
☐ Asian	☐ Non-Hispanic	☐ Private Insurance
☐ Black/African American		☐ None
☐ Hawaiian or Other Pacific Islander		☐ Unknown/Not Provided
☐ White		

PARENT/GUARDIAN SIGNATURE: _____**DATE**: _____

TO BE COMPLETED BY INDIVIDUAL CONDUCTING ORAL HEALTH REVIEW AND SENT HOME WITH CHILD.

Child's Name: _____Date: _____

Your child received an oral health review today. This oral health review does **not** replace the normal, yearly dental check-up. Dental x-rays were **not** taken. The oral health review shows the following need for your child:

1. ☐ **No need for dental treatment**. Continue regular check-ups.

2.☐ **Need dental treatment within 4-8 weeks,** possible cavity. Please make a dental appointment.

3.☐ **Need urgent dental treatment within 24-48 hours,** due to toothache, cavity, or infection. Please make a dental appointment as soon as possible.

MISSOURI DEPARTMENT OF HEALTH & SENIOR SERVICES
Office of Dental Health

Talk to your child about oral health! Visit our web page at oralhealth.mo.gov or scan the QR code with your phone.

For more information on where to find a dental home, please visit Delta Dental's Resource Guide at https://www.deltadentalmo.com/resourceguide.