Dear Parent or Guardian:

Our school, in partnership with the Missouri Department of Health and Senior Services, Office of Dental Health, is offering a **FREE** program to help prevent cavities. **With your permission**, a trained professional will check your child's teeth and apply fluoride varnish. This quick and safe treatment helps prevent tooth decay, which is one of the most common childhood diseases.

Fluoride varnish is recommended every 3–6 months based on your child's risk level. It's safe to use up to four times a year. Regular brushing, flossing, and healthy eating are also important for good dental health. The Office of Dental Health collects screening data to better understand the need of Missourians. Participating children will receive a free toothbrush, toothpaste, and information on how to care for their teeth. **Important: This service does not replace a regular dental check-up. It is recommended to visit a dentist twice 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 a dental screening and two applications of fluoride varnish, 3 to 6 months apart.

☐ **YES**, I want my child to receive a dental screening. I do not want my child to have fluoride varnish.

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

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

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

For data purposes only to be used by the Missouri Department of Health and Senior Services

Mark all that apply for race:
☐ American Indian/Alaskan Native
☐ Asian
☐ Black/African American
☐ Hawaiian or Other Pacific Islander
☐ White

Mark any that apply for your child:
☐ Sensory sensitivities
☐ Developmental disabilities
☐ Intellectual disabilities
☐ Chronic illness
☐ Auto-immune disorders
☐ Other _____

Mark one that applies for ethnicity:
☐ Hispanic
☐ Non-Hispanic

Has your child's caregiver OR a sibling had a cavity in the last 6 months?
☐ Yes
☐ No

Mark one that applies for your child's dental insurance (data purposes only):
☐ Medicaid/Missouri Managed Care
☐ Private Insurance
☐ None
☐ Unknown/Not Provided

Has your child had a cavity in the last 24 months?
☐ Yes
☐ No