Site:_____

(_____)
Patient Name

(_____)
ID Number

KIDS' SMILES

Oral Health Screening, Fluoride Varnish Application, Education and Referral Program

Personal Record (as part of health record)

Child's Name:_____ **Birthdate**:_____
Parent's Name:_____ **Age**:_____
Address:_____

I understand that my child will be screened by _____, fluoride varnish will be applied to my child's teeth, education materials and counseling will be provided concerning my child's and my own oral health, and a referral made to a local dentist if necessary. I understand that for the most benefit this program should be repeated every six months through the 5th grade. I understand that my child's teeth may be yellow for two or three days due to the varnish but will return to the original color. I understand that there will be no charge to me or my family for this service.

SIGNED:_____ Date:_____
Parent/Guardian

_____