West Allis Health Department

Fluoride Varnish Consent Form

Child's Last Name	First Name	M.I.	Birth-Month/Day/Year

Street Address	City	Zip Code

Circle: Male Female

Please circle answers to the following questions.

Does your child see a dentist regularly? (2 times per year)	Yes	No
Is your child in any other fluoride varnish program?	Yes	No
Does your child take fluoride supplements?	Yes	No
Is your child allergic to pine nuts or colophony resin?	Yes	No

List additional allergies:_____

Is your child taking any medications? Yes No

Please List:_____

Does your child have special health care needs? Yes No

Please List:_____

Do you have Medicaid/Badger Care health insurance? Yes No

Insurance ID # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

I give permission for my child to participate in the Fluoride Varnish Program. I have read the West Allis Health Department Fluoride Varnish Information sheet. I believe I understand the benefits and risks of the dental varnish application and have had a chance to ask questions that were answered to my satisfaction.

The treatment, which your child will receive in this program, is not meant to take the place of regular dental care. It is strongly recommended that you have a family dentist for routine dental care including any follow up care which may be recommended after your child has completed this oral health program.

I have had an opportunity to review the City of West Allis Privacy Practices and have had a change to ask questions (www.westalliswi.gov). I understand that this document provides an explanation of the ways in which personal health information may be used or disclosed by the West Allis Health Department and of the rights with respect to personal health information. I understand that the West Allis Health Department bills Medicaid for eligible services.

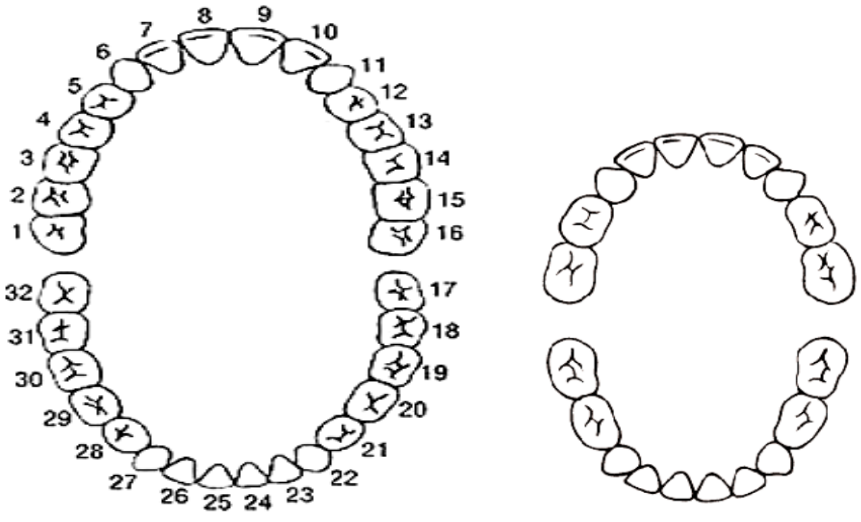
SIGNATURE – Parent or Guardian	Date Signed	Phone #

Site_____ Grade_____ Rm# _____

West Allis Health Department ■ 7120 West National Avenue ■ West Allis, WI 53214
414-302-8600 ■ 414-302-8628 Fax ■ www.westalliswi.gov

_____ _____ _____ **male / female** **D.O.B.**_____/_____/_____
NAME (Last) **(First)** **(M.I.)**

Ins.# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___



Screening Results:

_____
_____
_____
_____
_____
_____

Referral Given _____/_____/_____ **Cooperation Level** _____ **Toothbrush Prophy** _____/_____/_____

Fluoride Varnish

___**Oral Screen Date** ____/____/_____**Provider Signature** _____**Ins. Billed**_____

___**Application Date** ____/____/_____**Provider Signature** _____**Ins. Billed** _____

___**Application Date** ____/____/_____**Provider Signature** _____**Ins. Billed** _____

___**Application Date** ____/____/_____**Provider Signature** _____**Ins. Billed** _____

___**Application Date** ____/____/_____**Provider Signature** _____**Ins. Billed** _____

Additional Comments:

_____
_____
_____
_____
_____
_____
_____
_____