

Dear Parent or Guardian:

Your child's school will be providing free oral health screenings. This screening by a Registered Dental Hygienist is not a substitute for an examination by a dentist and will in no way interfere with any treatment received from a dentist. A copy of the screening report will be sent home with your child.

All district students will be screened unless there is parent / guardian notification otherwise. **If you do not want your child to participate in this free oral health screening, please fill out the bottom portion of the letter.**

In addition to the oral health screenings, fluoride varnish applications will also be available at **no cost to the student**. The application takes less than 1 minute, is painless, and works to strengthen the tooth and prevent cavities. Your child can benefit from fluoride varnish even if he/she already uses fluoride toothpaste or drinks fluoridated water. If your child has a dental home and receives regular fluoride varnish at their dentist's office, you may choose to decline the fluoride varnish services.

In order for your student to receive the fluoride application at **no cost to the student**, the "Consent for Fluoride Application" on the back of this letter will need to be completed and returned to the school by **March 31<sup>st</sup>, 2022**.

Your child's school will be screened on **April 14<sup>th</sup>, 2022**.  
Thank you for your cooperation!

Sincerely,

*Lynn Nightingale*

School Nurse

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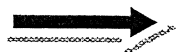
**Only sign here if you do not want your child to be screened**

School: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Student's name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

**Fluoride Varnish consent is on the back**





**CONSENT FOR FLUORIDE VARNISH APPLICATION**

Student's Name \_\_\_\_\_ Student's Birthdate \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Parent/Guardian Phone # \_\_\_\_\_

Parent/Guardian Address \_\_\_\_\_

Student's School \_\_\_\_\_ Gender of Student \_\_\_\_\_

Student's Teacher \_\_\_\_\_ Student's Grade Level \_\_\_\_\_

- Race:**  Asian  
 Black/African American  
 Hispanic  
 Native American  
 White/Caucasian

- Ethnicity:**  Hispanic/Latino  
 Not Hispanic/Latino

- Preferred Language:**  English  
 Spanish  
 Other \_\_\_\_\_

*As the parent or legal guardian of the above child, I understand that fluoride varnish is an effective way to improve your child's oral health in an effort to prevent painful cavities, expensive dental care and school absences. I give permission for my child to receive a fluoride varnish application.*

\*\*If your child has a pine allergy it is possible for them to have an allergic reaction to the fluoride varnish.

Salina Family Healthcare Center is covering the cost of services, but does require all available insurance coverage information for billing purposes. I will NOT be responsible to pay any portion of these services. **Salina Family Healthcare Center will bill my insurance provider for the services.** I hereby authorize Salina Family Healthcare Center to release the information requested by the insurance program necessary to process claims and authorize payment directly to Salina Family Healthcare Center Dental Clinic.

\_\_\_\_\_ My child is covered under KanCare # \_\_\_\_\_ or SSN \_\_\_\_\_

\_\_\_\_\_ My child has no dental coverage.

\_\_\_\_\_ My child has dental insurance from a private company.

**For Private Dental Insurance:**

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Group ID Number: \_\_\_\_\_ Member ID Number: \_\_\_\_\_

**Parent/Legal Guardian Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

Screened By: _____
Fluoride Applied By: _____
Date Performed: _____