SALINA FAMILY HEALTHCARE CENTER

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.

Kansas State Statute 72-6251 requires all district students to 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 by **December 2nd, 2025.**

Your child's school will be screened on **December 8th-11th, 2025.**
Thank you for your cooperation!

Sincerely,

Alysha Pierce
School Nurse

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

School: _____ Teacher:_____ Grade:_____

Student's name:_____

Parent/GuardianSignature:_____

Fluoride Varnish consent is on the back

SALINA FAMILY HEALTHCARE CENTER | Dental | Phone 785-826-9017 | Fax 785-826-9161

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:_____