Fluoride Varnish Program

Is Your Child At Risk for Early Childhood Tooth Decay?

Fluoride varnish applications prevent tooth decay. To find out if your child is at risk for early childhood tooth decay, read the points below. For each **yes**, check the box.

Does your child:

- ❑ live in an area with a non-fluoridated water supply, or a low natural fluoride level of less than 0.3mg/L? If you do not know, you can check with your local public health office.
- ❑ have visible plaque on teeth?
- ❑ have teeth brushed less than once a day?
- ❑ have a visible cavity or white chalky area on a tooth?
- ❑ have fillings, crowns, or extractions?
- ❑ see a dentist less than once a year?
- ❑ regularly eat foods or drink beverages that contain sugar (including natural sugars) between meals? This includes the use of a bottle or training cup filled with any liquid other than water.
- ❑ regularly use sweetened medicine?
- ❑ use a training cup or bottle after age 1?
- ❑ have a history of premature birth, with a low birth weight of less than 1500 grams (3 pounds)?
- ❑ have special health care needs?
- ❑ have a sibling, parent or caregiver with untreated cavities or existing fillings, crowns and extractions?
- ❑ have a sibling who had dental treatment under general anaesthetic?

If you did not check **any** box above, your child is at **low risk** for early childhood tooth decay. Your child would benefit from **one** fluoride varnish application each year.

If you checked **one or more** boxes above, your child is **at risk** for early childhood tooth decay. Your child would benefit from **two** fluoride varnish applications each year.

If you want your child to have fluoride varnish applications, complete the fluoride varnish consent form on the back of this page.

For more information, contact your local Public Health office.

Primary Health Services
3475 Albert St
Regina, SK S4S 6X6

1-800-667-7766
(306) 787-0889

Fluoride Varnish Program Consent

Child's Name: ________________ ______________ Date of Birth __ __/__ __/__ __ __ __
Last First (day/month/year)

Saskatchewan Health Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ❑ Female ❑ Male

Address: ____ Postal Code: __ __ ___ __ __ __
(City/Town)

Telephone Number: __________________ __________________ __________________
Home Work Cell

E-mail Address: ________________________ Local Public Health Office: ________________

1. Does your child have an allergy to colophony (pine resin): ❑ Yes ❑ No ❑ Don't Know
2. Does your child have an allergy to latex: ❑ Yes ❑ No ❑ Don't Know
3. Does your child have dental insurance/coverage: ❑ Yes ❑ No ❑ Don't Know
4. Has your child seen a dentist in the past year: ❑ Yes ❑ No ❑ Don't Know
5. How did you learn of the fluoride varnish program: ❑Another parent ❑Community Agency ❑Dentist ❑Preschool/Daycare ❑Public Health Nurse ❑Public Health Office ❑School

I consent to my child receiving the fluoride varnish. This includes a visual dental inspection and one or more applications of fluoride varnish. If there is a change in my child's allergies, I will contact the local public health office. This consent is active until I withdraw it. I can withdraw it by contacting my local public health office.
I also consent to the collection, use and storage of my child's dental health information in both electronic and paper form for public health and research purposes. If I provide an email address, I consent to receiving dental health information by email.

Parent/Legal Guardian Name (please print): ____

Parent/Legal Guardian Signature: ______________________________ **Date:** ___________________

Office Use Only

Number of Quadrants of Decay:	1 2 3 4	❑ No Risk ❑ Risk	
Pain/infection: ❑ Yes	**ECTD :** ❑ Yes	**Referral to:** ____________________	**Follow-up Complete**: ❑ (Pain/Infection/4 Quads)

Date dd/mm/yyyy	Provider Initials	Dental Screening Data								MH	Comment	Date to Return	SHS/Tob
		d	e	f	n/a	D	M	F	n/a				❑____
		d	e	f	n/a	D	M	F	n/a				❑____
		d	e	f	n/a	D	M	F	n/a				❑____
		d	e	f	n/a	D	M	F	n/a				❑____
		d	e	f	n/a	D	M	F	n/a				❑____