



North Central District Health Department is providing an opportunity for children to receive a fluoride varnish application for their teeth.

Fluoride Varnish Facts

- ☞ Fluoride varnish is a sticky, honey like material that is applied to the teeth with a small brush. It is called varnish due to its sticky consistency.
- ☞ **Fluoride varnish should be applied up to 6 times per year, and can decrease further cavity development by about 38%.**
- ☞ A typical fluoride varnish application costs from \$12 to \$40.
- ☞ Fluoride varnish is safe. It adheres to teeth once it comes in contact with saliva and is precisely applied to the teeth.
- ☞ Fluoride varnish is approved by the American Dental Association and the Federal Drug Administration.

This program should NOT replace your regular visits to the dentist or daily brushing and flossing. It is an additional protection against cavities for your child.

A public health coordinator and a Public Health Authorized Registered Dental Hygienist will be coming to your school to apply the fluoride.

- **This service is covered by Medicaid/Kids Connection insurance.**
- **If not insured by Medicaid/Kids Connection, a \$15 donation is helpful in order to provide this as an ongoing service.**
- **The \$15 donation is ONLY a suggestion; NO child will be turned away.**

North Central District Health Department
422 E. Douglas St.
O'Neill, NE 68763
Toll Free: 1.877.336.2406 or Fax: 1.402.336.1768



Please fill out and return to your school office.

Your child will receive a Free Toothbrush if you return this form COMPLETED

Child's Name: _____ Grade _____

Date of Birth: ___/___/___ Age _____ Sex ___M ___F

Parent / Guardian Name: _____

Address: _____

Phone: _____

1. Do you have a family dentist? _____ Yes _____ No
If Yes, Name of Dentist: _____

2. Has your child had any cavities in the past 12 months? _____ Yes _____ No

3. Does your child wear dental or orthodontic appliances? _____ Yes _____ No

4. Does your child have frequent sugary snacks or drinks? _____ Yes _____ No
Do not count foods eaten as part of a meal

5. Does your child receive Medicaid or Kids Connection? _____ Yes _____ No

Kids Connection or Medicaid # _____

6. Does your child have any allergies including latex? _____ Yes _____ No
If Yes, Please List:

_____ YES, I would like my child to receive fluoride treatment for prevention of tooth decay.

_____ NO, I do not want my child to receive fluoride treatment, but my child will still receive an oral exam.

_____ NO, I do not want my child to participate at all.

Signature of Parent / Guardian

Date

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