

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



Maine Center for Disease Control & Prevention  
A Division of the Maine Department of Health and Human Services



### School Oral Health Program (SOHP)

With your permission, a health professional will provide a free oral health screening and apply a fluoride varnish treatment to help strengthen teeth, twice during the school year.

The American Academy of Pediatrics (AAP), American Dental Association (ADA) and United States Preventive Services Task Force (USPSTF) recommend fluoride varnish treatments 2-4 times per year or every 3-6 months. This program does not take the place of regular check-ups at a dental office.

**Please complete the entire form, as all information is required, and return to school if you consent to oral health services:**

- Yes, I want my child to get a dental screening and fluoride treatment at school.
- No, I do not want my child to get a dental screening or fluoride treatment at school.

**Student's Name** \_\_\_\_\_ **Birth Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Preferred Name** (If Different from Above) \_\_\_\_\_

**Student's Sex Assigned at Birth:**  Male  Female **Preferred Pronouns**  She/her  He/him  They/them

**Dentist's Name** \_\_\_\_\_

**Parent/Guardian Name** (Please Print) \_\_\_\_\_

**Daytime Phone** \_\_\_\_\_ **Parent's Email Address** \_\_\_\_\_

**Home Address** \_\_\_\_\_

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

A report will be sent home with your student after the oral health services are performed which many include *intraoral photographs* of teeth with concerns (no x-rays will be taken)

**1. When was the last time your child went to the dentist?**

- In the past year  More than one year ago  Never

**2. Does your child have?**

- MaineCare (Medicaid)  Dental Insurance  No Dental Insurance

**Please Provide the MaineCare ID#** \_\_\_\_\_

(This information is used for billing purposes with certain outside organizations)

**3. List your child's health problems or allergies:** \_\_\_\_\_

If you have any questions regarding this form, please contact your child's school nurse or email [SOHP@MCD.ORG](mailto:SOHP@MCD.ORG)

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