Permission Form for *FREE* Dental Screening and Fluoride Treatment

Family Health Care
340 Southwest Boulevard
Kansas City, KS 66103
913-722-3100, ext 210
www.FHC-Smiles.org

Dear Parent/Guardian:

Please provide the following information:

Student's Name: ____

Address: ____
City: _____________ State: __________ Zip: ___________

Phone #: ____
Student's Date of Birth: ___________________________
Social Security Number: ____________________________

KANCARE/Medicaid # 001- ____

MOHealthNet# ____

Please circle one: Sunflower / Aetna / United / Home State / Missouri Care

Fluoride Varnish Application: Yes ____ No ____

On __________________a dental screening/check fluoride placement will be provided to students who have parental permission. This will be a visual screening/check/fluoride placement and no dental X-rays will be taken. It does not take the place of a regular exam in a dental office. The findings of the screening will be sent home with the child for parents to look over.

Parent/Guardian Signature:____
Date: _________________________

Please return this form to the school by ____