



# Kaplan Barron Pediatric Group

a division of ONE Pediatrics

Drs. Roth, Lehocky, Katz, Belza, Abrams, Newstadt, Baum & Stone

3333 Bardstown Road  
Louisville, Kentucky 40218

Telephone: (502) 452-6337  
FAX: (502) 458-5327

## Fluoride Varnish Consent

Dear Parent/Caregiver:

A health professional will be applying fluoride varnish to your child's teeth as a means of preventing tooth decay (cavities).

Fluoride varnish is a protective coating that is painted on teeth. The varnish releases fluoride over a period of time, which strengthens teeth and prevents tooth decay. Tooth decay is the most common chronic disease found in children.

All insurances **SHOULD** cover fluoride varnish treatments as it is recommended by Bright Futures.

For your child to receive the fluoride varnish you will need to give permission by completing the form below.

\_\_\_\_\_  
**Child's name**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date of Birth**

➤ Is your child allergic to Pine Nuts? \_\_\_\_\_ YES or \_\_\_\_\_ NO

➤ Has your child seen a Dentist and/or had fluoride varnish applied in the last 30 days?  
\_\_\_\_\_ YES or \_\_\_\_\_ NO

\_\_\_\_\_ **YES**, I would like my child to receive the fluoride varnish application

\_\_\_\_\_ **NO**, I do not wish for my child to receive the fluoride varnish application

Does your child see a dentist at least once per year? \_\_\_\_\_ YES or \_\_\_\_\_ NO

If Yes, name of dentist: \_\_\_\_\_

\_\_\_\_\_  
Please print name of Parent/Caregiver \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Caregiver \_\_\_\_\_ Date \_\_\_\_\_