Grant County Health Department

111 South Jefferson Street
Lancaster, WI 53813-1672
Phone: (608) 723-6416 - Fax: (608) 723-6501

Medical Assistance # _____

Child's Last Name	Child's First Name	Date of Birth
Parent/Guardian Name	Address:	
Home Phone	Work Phone	Health History:
Known health problems or concerns:	Allergies:	Recent illness or hospitalizations:
Dentist Name:	Date of last visit:	Do you need help finding a dentist? YES NO

YES NO Does your child drink fluoridated water?	YES NO Does the child complain of mouth pain?
YES NO Take fluoride supplements	YES NO Does the child take a bottle to bed?
YES NO Use fluoride toothpaste	YES NO Walk around with a bottle or cup?
YES NO Has the child ever had cavities?	YES NO Does your child get help brushing his/her teeth?
YES NO Does the child or family members have untreated cavities?	YES NO Has your child had a bad dental experience?

I understand that fluoride varnish helps to protect teeth from cavities. Fluoride varnish may be applied to my child's teeth up to three or four times a year. My child's teeth may look yellow for 24 hours. After fluoride varnish application, I should not give my child crunchy foods the rest of the day. The oral screening is not a complete dental exam. Permission is valid for 12 months unless withdrawn by guardian/parent.

☐ YES, I give permission for my child to participate in the Early Childhood Cavity Prevention Program.

☐ NO, I do not give permission for my child to participate in the Early Childhood Cavity Prevention Program.

Signature of Parent/Guardian	Date Signed

OFFICE USE ONLY:

Untreated Caries
☐ No untreated cavities
☐ Untreated cavities

Early Childhod Caries
☐ No ECC
☐ ECC present

Caries Experience
☐ No caries experience
☐ Caries experience

Treatment Urgency
☐ No obvious problem
☐ Early dental care
☐ Urgent care

Child has Special Health Care Needs
☐ No
☐ Yes
Specify needs: (optional)

Comments

Reddened/Inflamed/ Ulcered Gums
☐ No
☐ Yes

# of teeth_____

Dental Referral Made: ☐ No ☐ Yes Dentist_____

☐ .25 ml (6 months to 5 years) ☐ .40 ml (6 years +) ☐ Instructions Given ☐ Continued on Back

Signature of RN_____ Date_____

OFFICE USE ONLY:

Untreated Caries

☐ No untreated cavities

☐ Untreated cavities

Early Childhod Caries

☐ No ECC

☐ ECC present

Caries Experience

☐ No caries experience

☐ Caries experience

Treatment Urgency

☐ No obvious problem

☐ Early dental care

☐ Urgent care

Child has Special Health Care Needs

☐ No

☐ Yes

Specify needs: (optional)

Comments

Reddened/Inflamed/ Ulcered Gums

☐ No

☐ Yes

# of teeth_____

Dental Referral Made: ☐ No ☐ Yes Dentist_____

☐ .25 ml (6 months to 5 years) ☐ .40 ml (6 years +) ☐ Instructions Given

Signature of RN_____Date_____

OFFICE USE ONLY:

Untreated Caries

☐ No untreated cavities

☐ Untreated cavities

Early Childhod Caries

☐ No ECC

☐ ECC present

Caries Experience

☐ No caries experience

☐ Caries experience

Treatment Urgency

☐ No obvious problem

☐ Early dental care

☐ Urgent care

Child has Special Health Care Needs

☐ No

☐ Yes

Specify needs: (optional)

Comments

Reddened/Inflamed/ Ulcered Gums

☐ No

☐ Yes

# of teeth_____

Dental Referral Made: ☐ No ☐ Yes Dentist_____

☐ .25 ml (6 months to 5 years) ☐ .40 ml (6 years +) ☐ Instructions Given

Signature of RN_____Date_____

OFFICE USE ONLY:

Untreated Caries

☐ No untreated cavities

☐ Untreated cavities

Early Childhod Caries

☐ No ECC

☐ ECC present

Caries Experience

☐ No caries experience

☐ Caries experience

Treatment Urgency

☐ No obvious problem

☐ Early dental care

☐ Urgent care

Child has Special Health Care Needs

☐ No

☐ Yes

Specify needs: (optional)

Comments

Reddened/Inflamed/ Ulcered Gums

☐ No

☐ Yes

# of teeth_____

Dental Referral Made: ☐ No ☐ Yes Dentist_____

☐ .25 ml (6 months to 5 years) ☐ .40 ml (6 years +) ☐ Instructions Given

Signature of RN_____Date_____