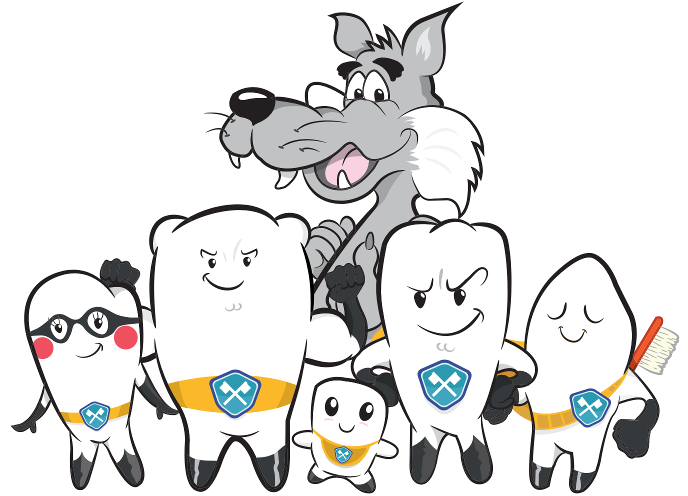

CONSENT FORM

The Teeth Team Tooth Brushing and Fluoride Varnish Programme

Surname	Forenames

Address

	Postcode

Date of Birth	Daytime tel (eg mobile)

Your child will be screened by a dentist and a fluoride treatment plan will be prepared if necessary.

1) Does your child take fluoride drops or tablets?

☐ Yes ☐ No

2) Does your child have allergies?

☐ Yes ☐ No

If yes, please give details

3) Have you ever been told your child has asthma?

☐ Yes ☐ No

4) Has your child been treated in hospital for asthma or kept in hospital for severe allergies?

☐ Yes ☐ No

STATEMENT OF PATIENT/PARENT/GUARDIAN

1. I give consent for my child (named above) to join the fluoride varnish programme.
2. I acknowledge that I have read and understood all the information in the leaflet provided, I have received written instructions and I have had the opportunity to ask questions.
3. I understand that my child should not take fluoride drops or tablets once they join this scheme.
4. I understand that the procedure will not be carried out if my child has a sore in their mouth.
5. I give permission for Teeth Team Ltd to use my child's health information for the purposes of administration, monitoring and evaluation. ☐ Yes ☐ No

Name (print)	Signature (of the PARENT/GUARDIAN)

Date	Relationship to child

CLINICAL DIRECTOR: D. WARD, B.D.S., M.B.A.

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