The Teeth Team
543-549 Anlaby Road,
Hull, HU3 6HP
01482 565 488

CONSENT FORM

The Teeth TeamTooth Brushing and Fluoride Varnish Programme

Dear Parent/Carer

Your child's school is taking part in the Teeth Team Programme which aims to improve the dental health of local children.

We will provide a dentist/therapist to come into your child's school annually to check the children's teeth and apply fluoride varnish every six months. This dental assessment will not replace your child's usual check-up and you will be informed if your child needs to see your usual dentist before your next scheduled appointment.

This Consent is a rolling consent and will last for the duration of your child attending this school, all we ask is that you inform the school if there are any changes to your child's medical history. If at any time you wish to withdraw consent you can do so by contacting Teeth Team at 543 Dental Centre on **01482 565 488**.

Please note: Teeth Team will not share any details of your child with 3rd party organisations.

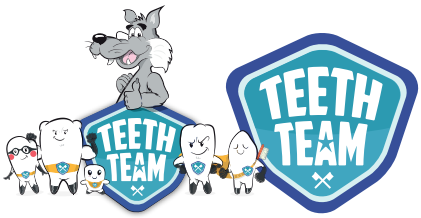
Please would you sign the consent forms overleaf and return it to your child's school so that your child can be included in the dental health programme.

Yours faithfully,

Teeth Team

CONSENT FORM

The Teeth Team Tooth Brushing and Fluoride Varnish Programme



TO THE TEETH TEAM + THE SCHOOL

Full Name (CHILD)

Date of Birth (CHILD)

Ethnicity (CHILD)

Male ☐ Female ☐

Do you visit a dentist regularly? ☐ Yes ☐ No

Please tell us of any problems or barriers you have experienced in gaining access to dental care.

Address

Postcode

Contact tel no.

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 any allergies? ☐ Yes ☐ No

3) Does your child have a Latex allergy? ☐ Yes ☐ No

4) Have you ever been told your child has asthma? ☐ Yes ☐ No

5) Has your child been treated in hospital for asthma or kept in hospital for severe allergies? ☐ Yes ☐ No

IF YES, PLEASE GIVE DETAILS

6) I agree for my child to brush their teeth every day at school ☐ Yes ☐ No

7) I agree for my child to have an annual dental assessment at school ☐ Yes ☐ No

8) I agree for my child to have fluoride varnish applied 2 x yearly at school this will also include an annual assessment carried out by a dentist. ☐ 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 Fluoride varnish will be applied to my child's teeth every 6 months.
4. I understand that my child should not take fluoride drops or tablets once they join this scheme.
5. I understand that the procedure will not be carried out if my child has a sore in their mouth.
6. I give permission for Teeth Team to use my child's health information for the purposes of administration, monitoring and evaluation.

Full Name (PARENT/GUARDIAN)

Relationship to child

Signature (of the PARENT/GUARDIAN)

Date

CONSENT FOR PROMOTIONAL MATERIAL

1. I give consent for photography and videography in relation to Teeth Team. I consent to the images of my child being used in the press/ social media and Teeth Team's websites.

Full Name (PARENT/GUARDIAN)

Relationship to child

Signature (of the PARENT/GUARDIAN)

Date