North Star HEALTH

School Based Dental Health

September 3, 2025

Dear Parents:

I am happy to announce that I will be returning to provide Dental Services this year, again partnering with the 802 Smiles Network, to those children in need of dental cleanings, dental sealants, fluoride applications, as well as silver diamine fluoride applications. My priority will be working with those children that do not presently have a dental home.

Good dental health is important to your child's well-being. Dental pain can interfere with learning, playing, being social, eating, and sleeping. Good oral habits are important to maintain daily and start at a young age.

Daily routines make oral care fun. Our children learn from us and it is important to have dental instruction be a part of their morning and evening routines. Once routines are learned, they are easy to remember and follow.
This program is referred to as School Based Dental Health at North Star Health. I will work closely with your school nurse and look forward to being of assistance in your child's future dental needs. I can be reached at 802-875-2878 or through your school nurse.

Attached please find the necessary permission forms to sign your child up for any of the above-referenced services that we plan on offering.

Sincerely,

Lisa Watson, RDH
School Based Dental Health at North Star Health
802-875-2878
Lisawatson@northstarfqhc.org

School Based Dental Health

North Star Health
802-875-2878

On behalf of my minor child, _____, I authorize a North Star Dental Hygienist to perform any and all of the routine dental procedures listed below, while at school. I understand these procedures are free of charge. CHECK the procedures which I **DO** want my child to have:

Dental Cleaning ☐

Sealants ☐

Fluoride Treatment ☐

Silver Diamine Fluoride Treatment (see additional form) ☐

I understand that this consent form is active for as long as my child is receiving care at school for the current school year.

School name: _____ **Grade:** _____

I understand that our dental hygienist will obtain additional contact or health information through the school nurse or administrator.

Parent signature: _____ Date: _____

Parent name, please print _____

Home Address: _____

Phone number: _____ Email: _____

Child's name: _____ **Date of birth:** _____

Child's dentist: _____ Date of last dental visit: _____

Allergies: _____

Medications: _____

Check here if your child needs antibiotic premedication needed before dental work?

Medical concerns: _____

Dental concerns: _____

Check here if you feel your child has a dental emergency? YES ☐

Check here if you are agreeable to have the school nurse receive a copy of the Report of my findings? ☐

Check here if give 802Smiles Network CONSENT to share data about your child & complete back of form. Thank You! ☐

School Dental Health Program – Consent for Services (Tier 4)

Please fill out the information below, sign and return it to your child's school.

Child's First and Last Name: _____ **Date of Birth:** _____

What treatment is provided through my child's 802 Smiles dental program?

Your school's program offers dental screenings, cleanings, fluoride varnish, silver diamine fluoride (SDF), and dental sealants. To receive SDF, you need to fill out an additional consent form; read more about SDF treatment on that form.

Do you want your child to have this treatment? There are three choices.

○ **YES, I want my child to participate in the School Dental Health Program**. I give permission for my child to receive a dental screening, cleaning, fluoride varnish, silver diamine fluoride (SDF), and dental sealants as needed.

I allow the School Dental Health Program to give my child's records to their primary dentist (listed on page 2) and to the Vermont Department of Health. I understand that records will be be used to coordinate treatment and evaluate how well this progam works. I understand that the records will be reviewed by a VT-licensed dentist who supervises the dental hygienist. I understand that treatment by the dental hygienist is limited and does not replace a regular dental exam or treatment by a licensed dentist. I understand that the dental hygienist may refer my child to a dentist or other specialist for additional treatment if the child needs treatment that the dental hygienist cannot provide.

○ **YES, I want my child to participate in the School Dental Health Program**. I give permission for my child to receive a dental screening, fluoride varnish, silver diamine fluoride (SDF), and dental sealants as needed.

I do not allow the School Dental Health Program to give my child's records to their dentist or to the Vermont Department of Health.

○ **NO, I do not want my child to participate in the School Dental Health Program.**

Please tell us why you don't want your child to participate in the program:

_____

This permission stays in effect until it is ended by the child's parent or legal guardian.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

If you said YES to any questions above, continue to the next page.

Secretary of State
Office of Professional Regulation

DENTAL EXAMINERS
SDF Informed Consent Form

Medical Record Number: _____
Patient Name: _____
Date of Birth: _____

Silver Diamine Fluoride (SDF), a liquid approved by the FDA for treatment of sensitive teeth, provides an effective means to temporarily slow active decay until dental treatment can be obtained.

The Procedure:

- Dry teeth.
- Apply SDF to cavities in very small amounts and allow it to dry for 1 minute.
- Do not eat or drink for one hour. After treatment, do not brush your teeth today.

Please let us know if you have one of the following allergies or pre-existing conditions as it may be a reason not to use SDF:

- Allergies to silver or other metals
- Painful mouth sores
- Any abnormal skin sensitivities.

Possible Side Effects:

- SDF will turn a cavity black. See pictures below.
- A metallic taste in the mouth, which will go away quickly.
- If SDF comes in contact with skin and/or gums, temporary staining will occur.
- If SDF is placed on a tooth that has a tooth colored filling, staining may occur.

Please note:

- The side effects listed above may not include all of the side effects reported by the drug's manufacturer. If you notice other effects not listed above, please contact us.
- Treatment of tooth decay with SDF may not prevent the need to place a regular filling in the affected tooth in the future to restore function and esthetics.
- SDF treatment should be repeated within the next six months if you have not yet received dental treatment.

I, _____, have read this form and understand the treatment. The treatment, including the risks and benefits, has been explained to me to my satisfaction and I have had the chance to ask questions. I understand that there is no promise that this treatment will be successful. I hereby give my consent to have a licensed dental hygienist perform this procedure.

Date: _____
Signature of Patient: _____
Signature of Patient's Parent, Guardian, or Legal Representative (if applicable):
_____
Signature of witness: _____

These teeth have been treated with SDF.