LINCOLN COUNTY
HEALTH DEPARTMENT

Shelley Hersil, Director
Health Officer

607 N. Sales Street, Merrill, WI 54452
715-536-0307
Fax - 715-536-2011

Dietary Fluoride Supplement Program

Fluoride Intake Assessment/Application Form

Household Last Name:_____ **Township of Residence:**_____

Mother's Name:_____
(Last) (First) (Middle I.)
Telephone Number:_____(Home)_____(Work)_____(cell)

Father's Name:_____
(Last) (First) (Middle I.)

Telephone Number:_____(Home)_____(Work)_____(cell)

Address: _____
(Street) (City) (Zip)

Family Physician: _____ **Family Dentist:** _____

1st Child's Name Last:_____
(Last) (First) (Middle I.)
Birthdate: _____ **Age:**_____ **Sex:** M____ F____

2nd Child's Name: _____
(Last) (First) (Middle I.)
Birthdate: _____ **Age:**_____ **Sex:** M____ F____

3rd Child's Name: _____
(Last) (First) (Middle I.)
Birthdate: _____ **Age:**_____ **Sex:** M____ F____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Is your home connected with a community (city) water supply?
_____Yes _____No If yes, indicate city:_____

2. Is your drinking water from a private well? _____Yes _____No
If yes, have you tested your well for fluoride? _____Yes _____No If yes, what year_____ level_____

3. If your water source is *not* fluoridated, does your child drink from a fluoridated water supply on a regular basis (such as school or daycare)? _____Yes _____No (If yes, please, answer question 4)

4. If yes, how many hours per day? _____
How many days per week? _____
How many weeks per year? _____

(over)

5. Is your child currently taking supplemental fluoride?
_____Yes _____No (If yes, please, answer question 9)

6. Please check type used: _____fluoride drops _____fluoride tablets
_____fluoride drops with vitamins _____fluoride tablets with vitamins

7. When was the last time your child saw a dentist?
_____

For Infants

8. Is your infant being fed formula being mixed with nursery water? _____Yes _____No

9. Is your infant being fed **ready to feed** soy-based formula?
_____Yes _____No If yes, how many ounces per day? _____ ounces

10. If your infant is being fed ready to feed soy-based formula, does your child drink other fluids? _____Yes _____No _____N/A

(If yes, please, answer question 7).

11. List the Type and Amount of Other Fluids consumed each day:
TYPE_____OUNCES PER DAY_____
_____
_____

12. Any questions regarding food and beverages that contain fluoride?

13. Any questions regarding fluorosis (too much fluoride)?

14. How did you learn about the program?

_____dentist _____doctor _____newspaper _____friend _____brochure _____poster _____other

(please list other)_____

_____ _____
(Signature of person completing form) *(Date)*

PLEASE RETURN THIS COMPLETED ASSESSMENT FORM TO:
Lincoln County Health Department, 607 N. Sales Street, Merrill, WI 54452
Office hours: 8 a.m. – 4:30 p.m., Monday – Friday

Office Use Only

Date Well Water Picked Up _____ Date Dietary Food/Beverage Handout Given_____
Well Water Test Results_____ Date of Results:_____
Date Health Information Authorization signed _____
Intake Form was Reviewed: Date_____ RN Initials_____
Qualifies for supplements _____ Yes _____ No RN Initials_____
Comments_____
_____
_____