

### What is SDF?

Silver Diamine Fluoride (SDF) is a liquid that can be brushed on teeth to stop tooth decay. It is applied to teeth without using needles or a drill, so it can be especially helpful for Vermonters who have difficulty accessing dental health care. Treatment of tooth decay with SDF may not prevent the need to place a regular filling in the affected tooth in the future.

### What's the procedure for applying SDF to my child's teeth?

- The dental hygienist will dry your child's teeth.
- They will apply SDF to cavities in very small amounts and allow it to dry for one minute.
- Note that SDF will turn a cavity black. See pictures below.
- Your child may have a metallic taste in their 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 inform the dental hygienist if your child has any of the following conditions:

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

### After the procedure:

- Your child should not brush their teeth for the remainder of the day.
- 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 your school nurse.
- If your child does not have a regular dentist, the dental hygienist will help you find a place where your child can receive ongoing, comprehensive dental care.
- SDF treatment should be repeated within the next six months if your child has not yet received dental treatment.

### Teeth that have been treated with SDF:



Photo Credit: Dr Jeanette MacLean



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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: \_\_\_\_\_

This permission is valid until revoked by the child's parent or legal guardian.