

**Self Management Goals for Parent/Caregiver**

Patient Name \_\_\_\_\_

DOB \_\_\_\_\_



*Regular dental visits for child*



*Family receives dental treatment*



*Healthy snacks*



*Brush with fluoride toothpaste at least 2 times daily*



*No soda*



*Less or no juice*



*Wean off bottle (no bottles for sleeping)*



*Only water or milk in sippy cups*



*Drink tap water*



*Less or no junk food and candy*



*Use xylitol spray, gel or dissolving tablets*

*Important: the last thing that touches your child's teeth before bedtime is the toothbrush with fluoride toothpaste.*

Self-management goals 1) \_\_\_\_\_

2) \_\_\_\_\_

On a scale of 1–10, how confident are you that you can accomplish the goals? 1 2 3 4 5 6 7 8 9 10

Signature \_\_\_\_\_ Date \_\_\_\_\_

Practitioner signature \_\_\_\_\_ Date \_\_\_\_\_