Fluoride And Caring for Children’s Teeth

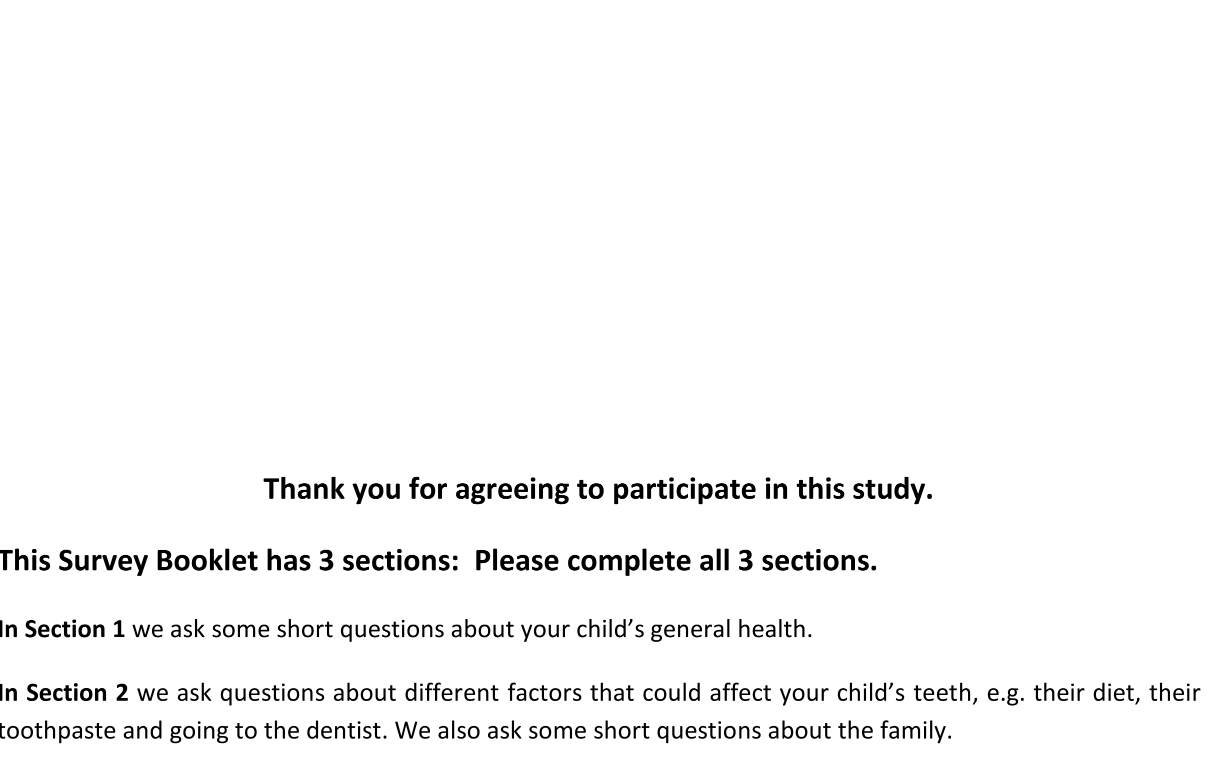
Parent Survey

A joint UCC/Health Services research project to inform national policy and planning of dental services

6th Class

Child’s name:

School:



Thank you for agreeing to participate in this study.

This Survey Booklet has 3 sections: Please complete all 3 sections.

In Section 1 we ask some short questions about your child's general health.

In Section 2 we ask questions about different factors that could affect your child's teeth, e.g. their diet, their toothpaste and going to the dentist. We also ask some short questions about the family.

In Section 3 we ask questions about how your child's oral health affects their wellbeing and everyday life, and how it affects the family.

Instructions

1. Most questions can be answered simply by putting a tick ✓ in the box next to the answer that applies to you.
2. Please complete all 3 sections.
3. When you have finished answering all of the questions, please put this booklet, the completed residential history questionnaire, the signed consent/assent form, along with the filled water bottle in the Ziplock bag, into the envelope provided and have your child return the sealed envelope to his/her teacher without delay.

SECTION 1

➢ We would like to know about your child's medical history

Child's name: ______________________________________ **Date of birth:** _____________

MEDICAL HISTORY

	YES	NO	Please provide details (USE BLOCK CAPITALS)
Is your Child...			
Attending or receiving treatment from a doctor, hospital, clinic or specialist?	☐1	☐2	
Taking any medicines from his/her doctor? (tablets, inhalers, creams, ointments, injections, other)	☐1	☐2	***Please write the names of any medications***
Does your Child...			
Suffer from any allergies?	☐1	☐2	
Have fainting attacks, blackouts, seizures or epilepsy?	☐1	☐2	
Have diabetes?	☐1	☐2	
Are there any other important aspects of your child's health that the dentist should know about?	☐1	☐2	

PARENT SIGNATURE: __________________________________ **DATE**: _____________

SECTION 2: Part 1

➢ In this section we would like to know about your child's toothbrushing, and use of toothpaste and mouthwash

1. At what age did you start cleaning/brushing your child's teeth?

- Before 12 months of age ☐1
- Between 12 and 18 months of age ☐2
- Between 19 and 24 months of age ☐3
- After 24 months of age ☐4
- My child's teeth are not usually brushed ☐5

2. At what age did you first start using toothpaste with your child?

- Before 12 months of age ☐1
- Between 12 and 18 months of age ☐2
- Between 19 and 24 months of age ☐3
- After 24 months of age ☐4
- My child does not use toothpaste ☐5

3. What type of toothpaste did you use when you first started using toothpaste with your child?

- Children's toothpaste with fluoride ☐1
- Children's toothpaste without fluoride ☐2
- Regular/Family toothpaste with fluoride ☐3
- Regular/Family toothpaste without fluoride ☐4
- My child does not use toothpaste ☐5

4. What type of toothpaste does your child use now?

- Children's toothpaste with fluoride ☐1
- Children's toothpaste without fluoride ☐2
- Regular/Family toothpaste with fluoride ☐3
- Regular/Family toothpaste without fluoride ☐4
- My child does not use toothpaste ☐5

5. Fluoride is added to toothpaste to help prevent tooth decay. Which of the following do you think might be the recommended fluoride content for toothpaste for children in Ireland? (ppm = parts per million)

- 500 – 750 ppm ☐1
- 1,000 – 1,500 ppm ☐2
- 2,000 ppm or more ☐3
- I don't know ☐4

Please tick one box for each age period in your child's life			
	Under Age 2	**From 2 to 3 years**	**Now**
6. **How often did/does your child brush his/her teeth with toothpaste?**	Never ☐1 Most days but not every day ☐2 Once a day ☐3 Twice a day ☐4 More than twice a day ☐5	Never ☐1 Most days but not every day ☐2 Once a day ☐3 Twice a day ☐4 More than twice a day ☐5	Never ☐1 Most days but not every day ☐2 Once a day ☐3 Twice a day ☐4 More than twice a day ☐5
7. **Have you ever noticed your child eating or licking toothpaste?**	Often ☐1 Sometimes ☐2 Never ☐3	Often ☐1 Sometimes ☐2 Never ☐3	Often ☐1 Sometimes ☐2 Never ☐3
8. **How much toothpaste did/does your child (or do you) use on his/her toothbrush?** (please circle the image that matches your answer)	1 ***(Full Brush)*** 2 ***(Pea-sized)*** 3 ***(Very small amount)*** 4 ***(None)***	1 ***(Full Brush)*** 2 ***(Pea-sized)*** 3 ***(Very small amount)*** 4 ***(None)***	1 ***(Full Brush)*** 2 ***(Pea-sized)*** 3 ***(Very small amount)*** 4 ***(None)***

9. These pictures show children rinsing their teeth after brushing. Which picture shows what your child usually does?

My child's teeth are not usually brushed ☐1

Picture 1
Using the toothbrush to rinse ☐2

Picture 2
Rinsing directly from the tap ☐3

Picture 3
Cupping hands to rinse ☐4

Picture 4
Using a glass to rinse ☐5

My child does not rinse ☐6

Other *(please specify)*: ☐7

____

10. Does your child usually use mouthwash (Tick one box only)

Every day ☐1
A few times a week ☐2
Once a week ☐3
Infrequently ☐4
Never ☐5 if **'Never'** Go to **Q13**

11. When your child uses mouthwash, is it usually

Immediately or shortly after brushing ☐1
At a different time to brushing ☐2

12. Does your child's mouthwash contain fluoride?

Yes ☐1 No ☐2 Don't know ☐3

13. Has your child ever taken a course of fluoride tablets or drops?

Yes ☐1 No ☐2 Don't know ☐3

Thank you for your help so far!

SECTION 2: Part 2

➢ We would now like to ask you about your child's diet

14. Was your child breast-fed as a baby?

Yes ☐1 No ☐2

***If you answered 'Yes'*, how long was your child breast fed for?**

Less than 2 weeks ☐1
Less than 2 months ☐2
2–3 months ☐3
4–6 months ☐4
Longer than 6 months ☐5

15. If you used formula to feed your baby, did you mainly use

Powdered formula ☐1
Ready-made liquid formula ☐2

16. What source of water did you mostly use to make up the formula?

Unfiltered tap water ☐1
Filtered (using a cartridge filter in a water jug) ☐2
Filtered at tap or under sink ☐3
Bottled water ☐4
Other *(please specify)*: ☐5

____

17. Now that your child is older, does he/she ever have a drink by the bedside in case he/she gets thirsty during the night?

Yes ☐1 No ☐2

If you answered 'Yes' what type of drink would he/she usually take?

Tap water ☐1
Bottled water ☐2
Squash (diluted)/fruit drink ☐3
Milk ☐4
Other *(please describe)*: ☐5

____

18. What type of <u>water</u> does your child usually drink?

Tap water mostly ☐1
Bottled water mostly ☐2
Both tap and bottled ☐3
My child does not drink water ☐4

19. What type of water do you usually use for preparing and cooking food?

Tap water mostly ☐1
Bottled water mostly ☐2
Both tap and bottled ☐3

20. If your child drinks tap water, is it

Unfiltered ☐1
Filtered (using a cartridge filter in a water jug) ☐2
Filtered at tap or under sink ☐3

21. In the last 24 hours, how often has your child had the following drinks? (Please tick one box for all drinks that apply)

	Not at all	Once	More than once	Don't know
Tap water	☐1	☐2	☐3	☐4
Bottled water	☐1	☐2	☐3	☐4
Fruit Juice	☐1	☐2	☐3	☐4
Diet Soft drinks/minerals/cordial /squash	☐1	☐2	☐3	☐4
Non-diet Soft drinks/minerals/cordial /squash	☐1	☐2	☐3	☐4
Milk	☐1	☐2	☐3	☐4
Flavoured milk	☐1	☐2	☐3	☐4
Tea with sugar/honey	☐1	☐2	☐3	☐4
Tea without sugar/honey	☐1	☐2	☐3	☐4
Coffee with sugar/honey	☐1	☐2	☐3	☐4
Coffee without sugar/honey	☐1	☐2	☐3	☐4
Hot chocolate	☐1	☐2	☐3	☐4

22. On a typical weekday, how often does your child have sweet food or sweet drinks <u>between meals</u> (for example, sweets, biscuits, cakes, juice, squash (diluted), fizzy drinks, fruit drinks etc.)? (Tick one box only)

Never ☐1
Once ☐2
Twice ☐3
Three times ☐4
Four times ☐5
Five times ☐6
Six times or more ☐7
Don't know ☐8

Thank you for completing the section on your child's diet. You have almost completed this survey.

SECTION 2: Part 3

➢ Please continue and answer the following questions on how you feel about the appearance of your child's teeth

23. Are you happy with the <u>colour</u> of your child's permanent (adult) front teeth?

Yes ☐1 No ☐2 Don't know ☐3

24. Have you noticed any brown, creamy or white marks on your child's permanent (adult) front teeth that don't rub off?

Yes ☐1 No ☐2 Don't know ☐3

25. How do you feel about the position/alignment/straightness of your child's permanent (adult) front teeth?

Very satisfied ☐1
Satisfied ☐2
No opinion/indifferent ☐3
Dissatisfied ☐4
Very dissatisfied ☐5

26. We would like to know what parents value most about their child's teeth. There are no right or wrong answers to this question. Please rank the following options from 1 to 4 in the order that you believe is most important for your child. Use only one number for each box and do not repeat any numbers.

1=most important; 2=second most important; 3=third most important; 4=least important

Having white teeth ☐

Having healthy permanent teeth with no fillings ☐

Having healthy baby (milk) teeth with no fillings ☐

Having straight teeth ☐

Thank you once again for completing this section on the appearance of your child's teeth.

SECTION 2: Part 4

➢ Kindly continue with the following questions about your child's attendance at the dentist

27. My child had his/her first visit to a dentist (including HSE/school dentist)

at the age of _________ *(Enter age in years)*

OR

My child has never been to a dentist ☐ 0 Go to **Q30**

28. How long is it since your child was at the dentist?

Less than 12 months	☐1
More than 12 months	☐2

29. When your child goes to the dentist (excluding orthodontic/braces), what type of dental service does your child usually attend?

HSE (School Dentist)	☐1
Private Dentist (Republic of Ireland)	☐2
Private Dentist (Northern Ireland)	☐3
Dental Hospital	☐4
Other *(please specify)*:	☐5

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Thank you!

SECTION 2: Part 5

➢ Please tell us a little about your family

30. What type of healthcare cover do you have?

Full medical card/GP visit card	☐1
Private health insurance e.g. VHI/Aviva	☐2
No healthcare cover	☐3
PRSI	☐4
Other *(please describe)*:	☐5

____

31. What is the highest level of education both Parents/Caregivers have completed to date?

	Mother/Female caregiver	Father/Male caregiver
Primary or less	☐1	☐1
Intermediate/Junior/ Group Certificate or equivalent	☐2	☐2
Leaving Certificate or equivalent	☐3	☐3
Diploma/Certificate	☐4	☐4
Primary degree	☐5	☐5
Postgraduate/Higher degree	☐6	☐6

32. Diet varies between different cultures and this can have an effect on dental health. We would be grateful if you could tell us if your ethnic or cultural background is

Irish ☐1 Other ☐2 *(Please specify)*:__________________________

Thank you for that information – nearly there! Just one more section to complete.

SECTION 3

- This section asks about the effects of oral conditions on your child's wellbeing and everyday life: we are interested in any condition that involves teeth, lips, mouth or jaws

Please **do not discuss the questions with your child,** as we are interested only in the parents' perspective in this part of the survey.

33. How would you rate the health of your child's teeth, lips, jaws and mouth?

Excellent ☐1 Very Good ☐2 Good ☐3 Fair ☐4 Poor ☐5

34. How much is your child's overall well-being affected by the condition of his/her teeth, lips, jaw or mouth?

Not at all ☐1 Very little ☐2 Some ☐3 A lot ☐4 Very much ☐5

35. How much is the daily life of your family affected by the condition of his/her teeth, lips, jaw or mouth?

Not at all ☐1 Very little ☐2 Some ☐3 A lot ☐4 Very much ☐5

In this section, each question is followed by the same set of options. Please give the response that **best describes your child's experience**. If the question does not apply to your child, please answer with "Never".

36. During the last 3 months, how often has your child had:

a. Pain in the teeth, lips, jaws or mouth?

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

b. Food caught in or between the teeth?

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

c. Food stuck in the roof of the mouth?

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

d. Bad breath?

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

37. During the last 3 months, how often has your child:

a. Had difficulty biting or chewing firm foods such as fresh apple, corn on the cob or firm meat because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

b. Had difficulty drinking or eating hot or cold foods?

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

c. Taken longer than others to eat a meal because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

d. Had trouble sleeping because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

38. In the last 3 months, has your child:

a. Been upset because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

b. Been irritable or frustrated because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

c. Been anxious or fearful because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

d. Acted shy or embarrassed because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

39. In the last 3 months, has your child:

a. Missed school because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

b. Not wanted to talk to other children because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

c. Had a hard time paying attention in school because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

d. Avoided smiling or laughing when around other children because of his/her teeth, lips, mouth or jaws**?**

Never ☐1 Once or twice ☐2 Sometimes ☐3 Often ☐4 Everyday or Almost everyday ☐5 Don't know ☐6

Thank you for taking the time to complete this survey!

CHECKLIST

Please check you have done all of the following:

Completed and signed the Medical History section (page 2)	☐
Completed all sections of this Parent Survey	☐
Completed the Residential History Questionnaire	☐
Signed the Consent Form	☐
Asked your child to sign the Assent Form	☐
Taken a sample of tap water and securely fastened its bottle cap	☐

Now, please put this booklet, the completed Residential History Questionnaire, the signed Consent/Assent Form, along with the filled water bottle in the Ziploc bag, into the envelope provided and have your child return the sealed envelope to his/her teacher without delay.

Thank you.

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