

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



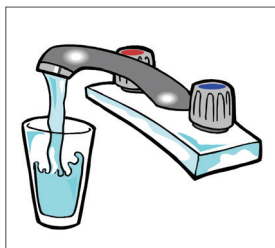
Less or no juice



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 _____