**My Oral Health Literacy: Home Checklist**

My Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date to Return Chart to School \_\_\_\_\_\_\_\_\_

Please put an “X” in the box when you complete the actions for health literacy:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Actions | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| Brush Teeth? |  |  |  |  |  |  |  |
| Rinse Teeth? |  |  |  |  |  |  |  |
| Floss  Teeth? |  |  |  |  |  |  |  |
| Read a Chapter? |  |  |  |  |  |  |  |
| Which  Chapter? |  |  |  |  |  |  |  |
| Parent Signature |  |  |  |  |  |  |  |