FORM I

Stockbridge-Munsee Community | Electa Quinney Head Start
FLUORIDE VARNISH PERMISSION

Child's Full Name **Child's Date of Birth**

☐ - YES, I DO WANT my child to receive fluoride varnish.

☐ - NO, I DO NOT WANT my child to receive fluoride varnish.

Child's Gender ☐ - Male ☐ - Female **Child's Age**

Address **Telephone**

Dentist's Name **Teacher's Name**

My Child Takes the Following Medications ☐ - None Please List

My Child is Allergic to ☐ - No Allergies Please List

My Child has Experienced the Following

☐ - Heart Surgery ☐ - Asthma ☐ - Epilepsy ☐ - Diabetes

☐ - Other

Behavior Considerations

I give my consent for the child named above to receive from Stockbridge Munsee Community Health and Wellness Center (SMHWC) and/or one of it's representatives, fluoride varnish services. I also hereby consent to the release and exchange of information including any personal health information and scheduling information between SMHWC and Head Start. In addition, by signing this form I am acknowledging that I have received the fluoride varnish fact sheet that is attached. This form will remain in effect for 12 months unless revoked in writing by me.

SIGNATURE

Parent Signature: **Date:**

For More Information about these Services Please Contact Head Start at 715.793.4993