Make a Child's Smile - Parental Consent Form

The Mississippi State Department of Health provides a preventive dental service for children in Head Start. With your permission, a dental hygienist will evaluate your child for obvious dental problems, such as a tooth cavity, and you will be informed of the results of your child's dental assessment. The dental hygienist will also apply a thin coating of fluoride varnish on your child's teeth to help prevent tooth decay. The dental hygienist may return later in the school year to provide a second fluoride application for your child, as feasible. These services are performed on-site at the school in a friendly environment. The hygienist may also assist the Head Start staff with your child's referral to a dentist for examination and needed treatment. For your child to receive these services, please check "Yes" and return the signed form to your child's teacher tomorrow.

YES ☐ I would like my child to have a dental assessment and receive fluoride varnish. Please write your child's name and sign and date the form in the appropriate space below.

NO ☐ I do not want my child to participate in this preventive dental program. To help us understand your concern, please write the reason why you do not want your child to participate on the other side and return the form to your child's teacher.

I hereby give consent for my child, _____, to receive dental services described above (oral health screening, education and fluoride varnish application) that are deemed necessary. I have placed a check mark in the appropriate box indicating my consent for treatment. I understand that the dental services described above will be provided at no additional cost to me or the Head Start and I will receive a written report about the services received. I also understand that this service does not replace a comprehensive examination by a dentist. I also authorize the Mississippi State Department of Health to release my child's health information to other dentists, physicians, nurses, health care providers and social service agencies who may provide consultation, referral, and treatment services for my child.

I further understand that MS Head Start Association grantee _____ will keep a copy of this screening consent and a copy of the written report I receive regarding my child's treatment.

Parent/Guardian Name (please print) _____

Contact Phone Number: _____

Parent/Guardian Signature _____ Date_____

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Form 372

PURPOSE

The purpose of the Make a Child's Smile Parental Consent Form is for the Office of Oral Health to obtain parental permission for prevention services in Head Start.

INSTRUCTIONS

The Office of Oral Health will forward the Parental Consent Form to the participating Head Start Center for consent. The Head Start Center will forward the form to children enrolled for parental consent. The Head Start will return the original form to the Regional Oral Health Consultant (ROHC). The ROHC will provide preventive services to those that have parental consent. The Head Start center will retain a copy of the consent and the original will be returned to the ROHC. This form is located in the Office of Oral Health.

OFFICE MECHANICS AND FILING

The ROHC will forward the Parental Consent Form to the Office of Oral Health and shall be filed in the current fiscal year head start center folder.

RETENTION PERIOD

Collected data is kept for seven years in the Office of Oral Health.