FLUORIDE MOUTHRINSE PROGRAM
CONSENT FORM

IMPORTANT!!!

This form must be filled out....
whether or not you permit your child to participate in the Fluoride Mouthrinse Program.

RETURN THIS FORM TO YOUR CHILD'S TEACHER IMMEDIATELY

~PLEASE PRINT~

CHILD'S NAME_____ *(CIRCLE ONE)* MALE FEMALE
(LAST) *(FIRST)* *(MIDDLE INITIAL)*

STREET ADDRESS_____ HOME PHONE_____

CITY/TOWN_____ ZIP CODE_____ CHILD'S AGE_____

DATE OF BIRTH_____ GRADE_____ TEACHER_____
(Month/Day/Year)

To the Principal:

I have received the letter of information about the Fluoride Mouthrinse Program in the school. I have reviewed and understand the contents of the letter and thereupon make the following decision:

~PLEASE CHECK ONE BOX, SIGN, AND DATE~

☐ **I DO** give permission for my child to participate in the Fluoride Mouthrinse Program. I understand that I may withdraw my child from this program at anytime without prejudice, by sending a written notice to the school.

☐ **I DO NOT** give permission for my child to participate in the Fluoride Mouthrinse Program.

X_____ _____

(Parent's or Guardian's Signature) *(Date)*