Southern Oregon Child and Family Council Inc.
1001 Beall Lane, PO Box 3697 - Central Point, OR 97502 – (541)734-5150 – FAX (541)734-2279

Child's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone #: _____

AUTHORIZATION FOR DENTAL HYGIENE SERVICES

During the school year we offer dental hygiene exams and fluoride varnish treatments at no cost to you. If you would like your child to receive these services they will be provided at your child's center by a Dental Hygienist up to three times during the school year.

Please initial one option, and sign below:

_____ No – I do **not** want my child to participate in this service.

_____ Yes – I would like my child to participate in the dental hygiene exams **with** fluoride varnish treatments

_____ Yes – I would like my child to participate in the dental hygiene exams **without** fluoride varnish treatments

If YES, please, **read and initial** the statement below.

As the responsible party, I hereby give consent for my child named above to receive dental hygiene examinations as indicated above during the time my child is enrolled in Head Start. I also give consent for release and exchange of information between Head Start, Capitol Dental, and the child's dentist. This consent will remain in effect for the duration my child is enrolled in Head Start. The results of all examinations will be placed in my child's Head Start file, and sent home to the guardian. By signing this form, I am also acknowledging that I have received a copy of Capitol Dental Care's Notice of Privacy Practices.

_____ I agree with the above statement.

Parent/Guardian Signature: _____ Date: _____

Capitol Dental

_____
Center