Dear Parent/Guardian:

This is to inform you that your child ___________________________ was examined by a dentist, Dr. ___________________________ at ___________________________ on ___________________________.

It was determined the following are necessary:

☐ Fillings are silver or plastic restorations.

☐ Crowns are made of stainless steel and placed on teeth that have large areas of decay.

☐ Pulpotomies (Pulp Treatments) are performed on teeth with large areas of decay affecting the nerves of the teeth.

☐ Extractions are the removal of teeth having enormous decayed areas which cannot be restored.

☐ Other (specify) ___________________________

☐ For your child’s comfort, medication may be used for numbing.

If your child has his/her own dentist or you do not want your child treated, notify your child’s teacher or call Head Start Health Coordinator at 955-6875.

I give my consent for the services checked above.

______________________________________________
(Parent or Legal Guardian)