

Dear Parents:

With the permission of the school Principal, the Marin County Dental Society will be conducting a dental health screening in your child's school on _____.

This screening will be a VISUAL CHECK only and will **not** use x-rays, mirrors, or explorers. There may be dental problems that cannot be seen at the time of the screening. Routine dental appointments are very important to detect and prevent damaging dental diseases.

Results of the screening will be sent home with your child. If you do not have a family dentist, please contact the Marin County Dental Society at 472-7974 for a referral.

Please check, sign, and return the form below to your child's teacher as soon as possible.

PARENTAL DENTAL CONSENT FORM

Child's Name: _____ Age: _____

Teacher: _____ Grade: _____ Room: _____

- () Please allow my child to participate in the dental screening at school.
- () My child has recently seen a dentist and is under treatment.
- () I do not wish my child to see the dentist at this time.

Parent's Signature: _____ Date: _____

