

**WASHINGTON COUNTY HEALTH DEPARTMENT
SCHOOL BASED WELLNESS CENTER
DENTAL SCREENING PROGRAM**

PARENTAL CONSENT

Dear Parent/Guardian:

Washington County School Based Wellness Center is please to offer dental screening services for your child. He/she will receive the following, **dental screening**, education, counseling and recommendations. For other dental treatment (i.e. filling, extractions, etc.) your child will need to be referred outside to the appropriate provider.

This prevention program is not meant to take the place of your regular dentist. Your child should receive a complete examination offered in a dental office setting, with x-rays, as often as recommended by the dentist.

In this program:

- A dentist will screen your child to determine which services may be provided or if a referral is necessary.
- A complete dental exam will not be performed.
- X-rays are not taken during this screening. Parents are responsible for annual x-rays with family dentist.

No fee is ever charged to the student or the parent for participating in this program.

I have read and understand the purpose of this School-Based Dental Screening Program. I recognize that school records may be used to obtain information not completed on the registration form. School-Based Wellness Center staff will have access to the Wellness Center Medical Records. You have my permission to release any Wellness Center information to my child's health care provider, MCO and dental provider.

I hereby give permission for my child to receive the following dental services:

★ Enrollment will be assumed if neither is checked.

Dental screening, education, counseling and referral recommendation.

No Dental Services.

Parent/Legal Guardian Signature _____ **Date** _____

Signature of Student _____ **Date** _____

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Western Heights Middle

School Based Wellness Center

School Year: _____

Dear Parent:

The School Based Wellness Center would like enrolled students to complete a survey. The survey helps us learn how much students know about safety, nutrition, fitness and growth and development.

The information obtained will be used to develop health education for the students. Your cooperation is requested.

The survey is optional. If you do not want your child to participate, please sign below. If you have any questions regarding the survey, please contact the Wellness Center Staff at 301-766-8407.

Thank you,

SBWC Staff

Child's Name: _____

I DO NOT WANT MY CHILD TO COMPLETE THE SURVEY.

Explain: (optional) _____

Signature

Date