

Shiocton School District
Fluoride Mouthrinse Program – Information and Consent
Annual Permission

Dear Parent,

Together, we are trying to help your child enjoy good dental health. Unfortunately, many school age children have tooth decay, which causes poor health, pain, and loss of time from school. The cost of treating dental disease is high. The use of fluoride is one way to prevent tooth decay.

We are inviting students to participate in a school fluoride mouthrinse program to help reduce dental decay. Under supervision and with your permission, your child will rinse once a week with a 0.2% neutral sodium fluoride mouthrinse solution. The solution is not swallowed. There are no known adverse effects associated with this procedure. We are offering this program at no charge to you, to help your child have healthy teeth.

Fluoride mouthrinse is a topical application of fluoride that helps strengthen the outside surfaces of the teeth. This fluoride mouthrinse program is not meant as a substitute for any other fluoride your child may be getting. The benefits of the fluoride mouthrinse program are in addition to benefits received from drinking fluoridated water, fluoride toothpaste, and receiving fluoride applications in the dental office. This program will help improve the dental health of your child, although it will not take the place of regular dental check-ups and proper tooth care at home. Please check with your child's dentist if you have questions about your child participating in the fluoride mouthrinse program.

Please fill out the form below and return to your child's teacher tomorrow. Your child can participate in this program only if you give your permission by signing and returning this permission slip. If you have any questions about this program, please call:

Rebecca Ecker, BSN, RN at 920-986-3351 ext. 714

Annual Permission for Fluoride Mouthrinse

_____ YES, I want my child to participate in this weekly dental program until the end of the school year. I understand that I may withdraw this permission at any time by notifying the school office in writing.

_____ NO, I do not want my child to participate in this dental program.

Name of child (First and Last)

Grade

Name of Teacher

Name of school

Signature of Parent or Guardian

Date