

**SEQUATCHIE VALLEY HEAD START
CONSENT FOR DENTAL TREATMENT**

**This form is to be used only when Head Start staff are taking a
Head Start child for treatment without the parent accompanying.
Treatment of this kind must have prior approval of the Health Manager.**

Dear Parent,

This is to inform you that you child, _____ was examined by a
Dentist, Dr. _____ on _____. It was determined

That the following dental services are necessary:

(State approximate number where possible)

_____ fillings

_____ crowns (stainless steel or other)

_____ pulp treatments

_____ extractions (removal of teeth)

_____ other (specify) _____

Note: If the dentist will be using any drug for pre-medication or if he/she will be using nitrous oxide (laughing gas) as sedation, the name of the drug/drugs and/or the nitrous oxide must be listed below, prior to the parent signing the consent form.

Other comments:

I hereby give my consent for the services listed above to be performed on my child.

Parent or Legal Guardian Signature

Date

Witness Signature

Date

(White copy – center – yellow copy – HS Office)