Alachua County Public Schools
Early Intervention Services
Head Start/VPK

CONSENT FOR DENTAL TREATMENT

Dear Parent/Guardian:

This is to inform you that your child _____ was examined by a dentist,
(name)
Dr. _____ at _____ on _____.
(location) (date)

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 <u>do not</u> want your child treated, notify your child's teacher or call Head Start Health Coordinator at 955-6875.

<u>I give my consent for the services checked above.</u>

_____
(Parent or Legal Guardian)