

HARMONY TOWNSHIP SCHOOL
Phillipsburg, New Jersey
September 2009

SCHOOL DENTAL DISEASE PREVENTION PROGRAM
PARENT PERMISSION FORM

Dear Parent:

The Harmony Township School is cooperating with the Dental Health Program of New Jersey State Department of Health to provide a supervised fluoride mouthrinse program at your child's school.

This program, called Save Our Smiles, will make available to our children one of the most effective measures that prevent the ravages of tooth decay. Those children who are participating in the program will be closely supervised while they rinse with a weak solution of fluoride. This solution is swished in the mouth for one minute and then emptied into a disposable cup. The procedure will be performed once per week for the entire school year in grades 1st thru 6th.

Studies have repeatedly shown that children who rinse weekly with a fluoride solution are likely to have 20-50% fewer cavities than those who do not rinse with the solution.

The fluoride mouthrinse program is perfectly compatible with any other dental disease prevention measures that your family might use. The fluoride mouthrinses and fluoride applications in dental offices can all be combined to provide additional benefits, even in communities that have fluoride added to their water supply.

Participation in the fluoride mouthrinse program is voluntary and there is no cost to you. This program does not eliminate the need for proper home care and regular dental check-ups. The program has been endorsed by the American Dental Association, the New Jersey Dental Association and the American School Health Association.

You are free to withdraw your consent for participation at any time.

Sincerely,

Jill Broschius, R.N.

Harmony Township School
Fluoride Mouthrinse Program 2009 - 2010

Please complete and return this form by September 8, 2009. ONLY if you do not wish your child to participate. If this form is not returned your child will be placed in the fluoride rinse program.

_____ Please excuse my child from the Fluoride Mouthrinse Program.

NAME OF CHILD _____ AGE _____
(Last) (First) (MI)

TEACHER _____ GRADE _____

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____