CENTRAL MISSISSIPPI INCORPORATED
Head Start Program
101 South Central Avenue
P.O. Box 749
Winona, MS 38967

Phone: (662)283-2227
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CONSENT FOR DENTAL TREATMENT

Dear ______________________________ ,

This is to inform you that your 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 premedication 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:

____

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____

I hereby give my consent for the services listed above to be performed:
___ Without my being present ___ Only in my presence
___ Check here if you would like to be notified prior to each dental appointment.

____________________ ____________________
(Parent or Legal Guardian) (Date)

Assurance of Confidentiality: All of the information you provide helps us to deliver services most appropriate for your family needs. You may prefer not to share some information with us. However, some information is required to determine eligibility. All information is held in strict confidence.