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

Phone: (662)283-2227
Fax: (662)283-5777

Denial of Consent for Dental Exam

As parent or legal guardian of _____
(Child's Name)
it is my desire that no dental exam be provided to my child by Central Mississippi, Incorporated Head Start Program. I understand that this exam has been recommended and it will be provided free-of-charge. I accept consequences of this action and in no way hold Central Mississippi, Incorporated Head Start Program responsible for any future problems resulting from lack of dental exam.

Parent or Legal Guardian _____ Date _____

Witnessed by _____ 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.