

**STAMFORD PUBLIC SCHOOLS**  
**FLUORIDE RINSE PERMISSION FORM**

Dear Parent:

The Stamford Health Department Dental Health Program is offering a weekly fluoride rinse program. This preventive program has been shown by the National Dental Research to reduce cavities (dental caries) an additional 35% in fluoridated areas.

The program is offered in grades 1-5. Permission will become part of your child's permanent record and will remain in effect until rescinded in writing by parent or guardian.

This program is a supplement to good dental health and is offered in addition to your child's regular dental care and preventative procedures provided by your private dentist. Each participating student is given a paper napkin and a cup containing 10ml (2 teaspoons) of 0/2% neutral sodium fluoride solution. The solution is swished around the teeth for one minute, and then emptied back into the cup. This school program is successful throughout the United States.

This fluoride program is important to the dental health of your child and is endorsed by the Stamford Dental Society, the State Department of Health, CT Dental Hygienists' Association and the American Dental Association. If you have any questions, please call 977-4846.

Participation is entirely voluntary, and at no cost. If you wish to have your child participate in this preventive program, please sign the permission slip below and return this form to your Public Health Dental Hygienist at your child's school.

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Fluoride Rinse Program begins in 1<sup>st</sup> grade and is offered until 5<sup>th</sup> grade.

Since continued participation is desirable, this permission slip will become a permanent record of the child's dental record and remain in force until rescinded by the parent or guardian.

Name of Student: \_\_\_\_\_ Grade: \_\_\_\_\_ Birth Date: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_

\_\_\_ I want my child to participate in the weekly oral rinse program.

\_\_\_ I do not want my child to participate in the weekly oral rinse program.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Please Print Dentist's Name