SIERRA-PLUMAS JOINT UNIFIED SCHOOL DISTRICT

Dental Screening - Parental Consent
School Nurse, Dotti Bok, R.N.

Student:_____ **Grade:**_____

School_____ **Date of Screening:**_____**, 20__, at _____ __.m.**

☐ **Yes**, I, _____, am a parent of _____, and do hereby give the above-mentioned school my permission to allow my child to participate in a dental screening scheduled to take place on the date specified above and at the above-mentioned school.

☐ **No**, I, _____, am a parent of _____, and hereby choose **not** to allow my child to participate in a dental screening scheduled to take place on the date specified above and at the above-mentioned school.

_____ _____
(Signature of Parent or Guardian) (Date of Signature)

FORMS\N-DS-P (8/00)

SIERRA-PLUMAS JOINT UNIFIED SCHOOL DISTRICT

Dental Screening - Parental Consent
School Nurse, Dotti Bok, R.N.

Student:_____ **Grade:**_____

School_____ **Date of Screening:**_____**, 20__, at _____ __.m.**

☐ **Yes**, I, _____, am a parent of _____, and do hereby give the above-mentioned school my permission to allow my child to participate in a dental screening scheduled to take place on the date specified above and at the above-mentioned school.

☐ **No**, I, _____, am a parent of _____, and hereby choose **not** to allow my child to participate in a dental screening scheduled to take place on the date specified above and at the above-mentioned school.

_____ _____
(Signature of Parent or Guardian) (Date of Signature)

FORMS\N-DS-P (8/00)