

Dear Parent or Legal Guardian:

The Baltimore County Public Schools, in collaboration with the Baltimore County Department of Health, provides a school-based fluoride mouth rinse program to help prevent tooth decay. It is offered to our students whose source of home drinking water is an underground well and it is most beneficial to those who do not already receive daily fluoride tablets at home. Participation is entirely voluntary and without cost to you.

In our school, the program will be administered under the direction of the school health nurse. This weekly fluoride mouthrinse of 0.2% sodium fluoride solution will help prevent cavities even if your child receives periodic topical fluoride applications from your dentist.

If your child is taking daily fluoride tablets or is having orthodontic brackets placed on his/her teeth, please discuss with your dentist/orthodontist whether participation is recommended.

Each week, your child will be given a sealed, premeasured plastic cup containing 1/3 oz. of a clear fluoride solution. Under supervision, the child empties the contents of the cup into his/her mouth and swishes it for a minute. The solution is then spit back into the cup. If your child were to accidentally swallow the solution, it would cause no harmful effects.

Your permission is required in order for your child to participate. We encourage you to enroll your child in this valuable dental health program. Your permission will remain in effect as long as your child attends this school, the program is provided and you do not rescind the consent.

Please return the completed form without delay to the school nurse. If you have any questions regarding this program, feel free to contact the school nurse or the Office of Public Dentistry, Baltimore County Department of Health (410-887-2780).

Sincerely,

Principal _____

Date: _____

Name of Child _____ Date of Birth _____

I give permission for my child to participate in the fluoride Mouthrinse Program.
This permission remains in effect unless I notify the school nurse in writing.

I do not give permission for my child to participate in the fluoride Mouthrinse Program.

Signature of Parent or Guardian _____