MID-DELTA HEAD START
CONSENT FOR DENTAL TREATMENT

Dear ____________________________:

Your child, ____________________________ was examined by a dentist,

Dr. ____________________________ in ____________________________ on ____________

Name Location Date

This is to inform you that the following dental services are necessary:

[ ] Fillings
[ ] Crowns
[ ] Pulp Treatment
[ ] Extractions (removal of primary teeth)
[ ] Other

Complete this form after the first examination and the dentist has made his recommendations. This gives him my permission to provide the necessary dental services.

______________________________  ____________________________
Parent/Guardian Signature Date

______________________________  ____________________________
Parent/Guardian Signature Date

MDCS (5/98) HS-92