nmcaa
Head Start/Early Head Start

Release of Oral Health Information

As Parent/Guardian of _____, born _____,
Please Print Child's Name Child's Date of Birth

I hereby request and authorize Northwest Michigan Community Action Agency's Child Development Program and/or Intermediate School District Child Development Program to receive/share my child's most recent oral health screening which must include; exam, prophy, fluoride, x-rays (only if required for diagnostic use) and any other dental referrals/recommendations. These records will be used to meet the Head Start Standards in order to support each child's growth and school readiness. Consent is voluntary and may be revoked by the undersigned at any time. Revocation is not retroactive and therefore does not apply to an action that occurred before the consent was revoked.

_____ _____
Last or Next Oral Health Screening Date Dentist's Name and/or Office

_____ _____
Phone Number Address / City

_____ _____ _____
Parent/Guardian: Signature Printed Name Date

Not to exceed two years from the signature date, or upon exit of the program.