Fairhaven Public Schools
Health Services

Weekly Mouth Rinse Program Parent Permission Slip

Dear Parent or Guardian:

Our school has an opportunity to participate in the Weekly Fluoride Mouth rinse program this year. The program will be coordinated and funded by the **Massachusetts Department of Public Health, Office of Oral Health.**

This simple method of applying fluoride has been demonstrated to be safe and effective in reducing tooth decay 20%-40%. Under supervision, participating students will rinse their mouths in school with 10 ml. (2 tsps.) of 0.2% solution of neutral sodium fluoride for one minute each week. The solution is not swallowed.

The Food and Drug Administration has approved the 0.2 % sodium fluoride mouth rinse as a safe and effective means of preventing tooth decay. There are no known adverse effects associated with this procedure.

This program will help improve the dental health of your child although it will not take the place of regular dental checkups and proper tooth care at home.

FLUORIDE MOUTHRINSE IS BENEFICIAL. IT IS NOT MEANT AS A SUBSTITUTE FOR ANY OTHER FLUORIDE YOUR CHILD MAY BE GETTING EITHER BY FLUORIDATED WATER, FROM YOUR DENTIST OR BY PRESCRIPTION. Do not use the OTC Fluoride rinses at home while your child is participating in the weekly fluoride rinse program. Continue to brush with fluoride toothpaste. You may resume the OTC fluoride rinses during the summer if you wish.

Participation in the mouth rinse program is voluntary and there is no cost to you. We encourage you to allow your child to participate in this valuable health program. Your child can receive this program only if you give your permission by signing and returning this entire letter to your child's school nurse. Please return the slip whether you check "**YES or NO**".

If at any time you have a question about the program, you may call Denise Valois, School Nurse Leader

at 508-979-4074, or email her at dvalois@fairhavenps.net

_____**Yes**, I would like my child to participate in the weekly fluoride mouth rinse program.

_____**No**, I would not like my child to participate in the weekly fluoride mouth rinse program.

_____ _____

Name of Student Signature Parent/Guardian

_____ _____ _____

School Teacher/Grade Date