NORTHWEST TERRITORIES
Health and Social Services Authority

Consent for to Screen & the Fluoride Varnish Program

Child's Name: _____ Date of Birth: _____

Health Care #: _____ Treaty Status #: _____

Address: _____

Phone #: _____

I hereby consent to the administration of fluoride varnish on my child during his or her Well Child visits at the Community Health Centre. The benefits AND risks for the fluoride varnish application have been explained to me.

I understand that I have the right to refuse this treatment.

_____	_____	_____
Signature of Patient/Parent/Guardian	Relationship	Date/Time
_____	_____	_____
Signature of Witness	Witness Name Printed	Date/Time