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 dental screenings at school/kindergarten. 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