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Santé et Services sociaux Québec

DT9310

Child's last name	Record no.
First name	
Health insurance number	Expiry Year Month
Date of birth Year Month Day	Sex ☐ M ☐ F
Address (no., street)	
City	Postal code

Complete only if you **REFUSE** to allow your child to participate in the dental screening activity

REFUSAL

TO PARTICIPATE IN THE SCHOOL-BASED DENTAL SCREENING ACTIVITY

If you REFUSE to allow your child to participate in the school-based dental screening activity, please complete all the shaded sections in this form and sign and return it to your child's teacher **within the next three days**.

Additional information

Parent's 1 first and last name	Parent's 2 first and last name
Name of school	
Teacher's name and group number	

I REFUSE to allow my child, _____ ,
(child's first and last name in block letters)

to participate in the school-based dental screening activity carried out by the public health dental hygienist.

Parent's or guardian's first and last names: _____
(in block letters)

Parent's or guardian's telephone numbers:

Home (Area code, Number)

Office (Area code, Number, Ext. no.)

Cell phone (Area code, Number)

X _____ Date (Year, Month, Day)
Parent's or guardian's signature