

COMPLETE AND RETURN FORM TO YOUR SCHOOL FOR YOUR CHILD
TO RECEIVE MEDICAL AND DENTAL SERVICES ON THE MOBILE UNIT

Dear Parent or
Guardian:

Want Your Child to Participate? Complete this form and return it to your child's school
within the next two (2) days. Complete all insurance and health history information. The
information c6.9 (i)Tt6 Tw)6.9e4 with 2 (u)5 (r.8 (xt)-5.1 (t)-17.2 (w)5.2 (o)-12 ((-10.4 (2)-12 (

Date of the last time your child saw a dentist or doctor? Dentist: _____ Doctor: _____