Dear HES Families,

Our school has an opportunity to participate in the Weekly Fluoride Mouth Rinse program this year. The program is coordinated and funded by the Massachusetts Department of Public Health Office of Oral Health. The Food and Drug Administration has approved the 0.2% weekly sodium fluoride mouth rinse as a safe and effective means of preventing tooth decay. 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 10ml (2 tsp.) of 0.2% neutral sodium fluoride solution for one minute each week. The solution is NOT swallowed. There are no known adverse effects associated with this procedure. This program will help improve dental health of your child, although it will NOT take the place of regular dental check-ups and proper tooth care at home.

FLOURIDE MOUTHRINSE IS BENEFICIAL. IT IS NOT MEANT TO BE A SUBSTITUTE FOR ANY OTHER FLOURIDE YOUR CHILD MAY BE GETTING, EITHER BY FLOURIDE WATER, FROM YOUR DENTIST, OR BY PRESCRIPTION.

Participation in the fluoride program is voluntary and there is no cost to you. We encourage you to allow your child to participate in this voluntary health program. Your child can participate in the program only if you give your permission by signing and returning the bottom half of this letter to your child's teacher. Please return the slip whether you check "YES" or "NO".

If at any time you have questions about the program, you may call Kirsten Kennedy-Alvarado (School Nurse) at 1 (413) 582-6454. The program will begin at the end of October so **please sign the form below and return it to your child's teacher before November.**

Volunteers are needed to help with this program. The program takes place Friday mornings from 8:20-8:40am. Commitment is flexible.

Sincerely,

Kirsten Kennedy-Alvarado RN BSN (School Nurse for HES)

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_____ YES, I want my child to participate in the weekly fluoride mouth rinse program.

_____NO, I do not want my child to participate in the weekly fluoride mouth rinse program.

_____ _____

Name of Student Signature of Parent

_____ _____

Date Teacher

I WOULD LIKE TO VOLUNTEER APPROXIMATELY 20 MINUTES PER WEEK WITH THE FLOURIDE MOUTHRINSE PROGRAM.

YES _____ NO_____

SIGNATURE: _____