COMPLETE AND RETURN FORM TO YOUR SCHOOL FOR YOUR CHILD TO RECEIVE MEDICAL AND/OR 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 (iTt6 Tw)6.9e4tithig2 (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: _____