Parent/Guardian Notification

| in grades will be screened participate. Ora critical compond to opt out of the the page. If you | in compliance with Kansas Standard I unless the parent/guardian doesnot be alth is an important part of continuous the child's ability to learn as screening, please fill out and recond to the continuous participate, a copy of the continuous participate. | |
|----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| be sent home w | rith | |
| | stions, feel free to call me at scho | ool or by e-mail a you for your cooperation! |
| Sincerely, | | |
| USD | School Nurse | |
| | | |
| I do not wi | sh to have my child participate in | n the free dental screening. |
| Student Name: | | Grade: |
| Parent/Guardia | n Signature: | |

