

## Consent forms

### Sample Passive Consent Cover Letter for Parents or Caregivers

#### Letterhead

Form Approved  
OMB No. 0920-xxxx  
Exp. Date xx/xx/xxxx

Dear Parent or Guardian:

Your child's school has been chosen to take part in the state health department's *Smile Survey*. The purpose of the *Smile Survey* is to gather information about the dental health needs of children throughout {state}. This will allow the health department to create a plan to improve oral health for all of {state}'s children.

If you choose to let your child participate, a dentist or dental hygienist will perform a one-minute "smile check" using only a mouth mirror. They will wear dental gloves and use a new, disposable, sterilized mirror for each child. Results of your child's assessment will be kept private, and your child will not be named in any reports.

Your child will receive a toothbrush and a letter to take home to inform you of the screening results. If you need assistance obtaining dental care or insurance, please contact the school nurse or social worker for resources. This screening does not take the place of regular dental check-ups. Even if you have a family dentist, we encourage you to participate in the *Smile Survey*. By surveying all children in selected schools, we will have a better understanding of the dental health needs of children throughout {state}.

***If you do not wish for your child to have this quick "smile check", please check the NO box below and return the form to your child's teacher by {date}. If you want your child to have a "smile check" you do not need to return this form.***

As you know, a healthy mouth is part of total health and wellness and makes a child more ready to learn. By letting your child take part in this dental screening, you will help contribute new information that benefits all of {state}'s children. If you have any questions about the *Smile Survey*, please contact Susan Smith at (333) 555-5555 x1234 or by email at [ssmith@state.doh.gov](mailto:ssmith@state.doh.gov).

Sincerely,

Name, title, affiliation

 \_\_\_\_\_

#### Smile Survey

***If you do not want your child to have a dental screening, please check the NO box, sign, and return to your child's teacher.***

Child's Name: \_\_\_\_\_

Child's Teacher: \_\_\_\_\_

\_\_\_\_ NO, I do not want my child to receive a dental screening

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Parent/Guardian Signature

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Date

Public reporting burden of this collection of information varies from 431 to 2,570 hours with an estimated average of 1,183 hours per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

# Sample Positive Consent Cover Letter for Parents or Caregivers

## Letterhead

Form Approved  
OMB No. 0920-xxxx  
Exp. Date xx/xx/xxxx

Dear Parent or Guardian:

Your child's school has been chosen to take part in the state health department's *Smile Survey*. The purpose of the *Smile Survey* is to gather information on the dental health needs of children throughout {state}. This will allow the health department to create a plan to improve dental care for all of {state}'s children.

If you choose to let your child participate, a dentist or dental hygienist will perform a one-minute "smile check" using only a mouth mirror. They will wear dental gloves and use a new, disposable, sterilized mirror for each child. Results of your child's assessment will be kept private, and your child will not be named in any report.

Your child will receive a toothbrush and a letter to take home to inform you the screening results. If you need assistance obtaining dental care or insurance, please contact the school nurse or social worker. This screening does **not** take the place of regular dental check-ups. Even if you have a family dentist, we encourage you to participate in the *Smile Survey*. By surveying all children in selected schools, we will have a better understanding of the dental health needs of children throughout {state}.

***Please complete and sign the attached consent form. This will allow your child to be in Smile Survey. Return the form to your child's teacher by {date}.***

As you know, a healthy mouth is part of total health and wellness and makes a child more ready to learn. By letting your child take part in this dental screening, you will help contribute new information that benefits all of {state}'s children. If you have any questions about the *Smile Survey*, please contact {Susan Smith at (333) 555-5555 x1234 or by email at [ssmith@state.doh.gov](mailto:ssmith@state.doh.gov)}.

Sincerely,

Name, title, affiliation  
Enc.

Child's Name: \_\_\_\_\_

\_\_\_\_ **Yes, I give permission** for my child to have his/her teeth checked.

\_\_\_\_ **No, I do not give permission** for my child to have his/her teeth checked.

\_\_\_\_\_

Public reporting burden of this collection of information varies from 431 to 2,570 hours with an estimated average of 1,183 hours per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

# Sample Positive Consent Cover Letter for Parents or Caregivers with Questionnaire

## Letterhead

Form Approved  
OMB No. 0920-xxxx  
Exp. Date xx/xx/xxxx

Dear Parent or Guardian:

Your child's school has been chosen to take part in the state health department's *Smile Survey*. The purpose of the *Smile Survey* is to gather information on the dental health needs of children throughout {state}. This will allow the health department to create a plan to improve oral health for all of {state}'s children.

If you choose to let your child participate, a dentist or dental hygienist will perform a one-minute "smile check" using only a mouth mirror. They will wear dental gloves and use a new, disposable, sterilized mirror for each child. Results of your child's assessment will be kept private, and your child will not be named in any report.

Your child will receive a toothbrush and a letter to take home to inform you of the screening results. If you need assistance obtaining dental care or insurance, please contact the school nurse or social worker. This screening does **not** take the place of regular dental check-ups. Even if you have a family dentist, we encourage you to participate in the *Smile Survey*. By surveying all children in selected schools, we will have a better understanding of the dental health needs of children throughout {state}.

***Please complete and sign the attached consent form for your child to participate in the Smile Survey. Return the form to your child's teacher by {date}. On the back is a questionnaire to help the health department address challenges families in {state} experience accessing dental care. We'd appreciate it if you would answer the questions and return it with your child.***

As you know, a healthy mouth is part of total health and wellness and makes a child more ready to learn. By permitting your child to take part in this dental screening, you will help contribute new information that benefits all of {state}'s children. If you have any questions about the Smile Survey, please contact {Susan Smith at (333) 555-5555 x1234 or by email at [ssmith@state.doh.gov](mailto:ssmith@state.doh.gov)}.

Sincerely,

Name, title, affiliation  
Enc.

Child's Name: \_\_\_\_\_

\_\_\_ **Yes, I give permission** for my child to have his/her teeth checked.

\_\_\_ **No, I do not give permission** for my child to have his/her teeth checked.

Public reporting burden of this collection of information varies from 431 to 2,570 hours with an estimated average of 1,183 hours per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

# Sample Verbal Consent Form

Form Approved  
OMB No. 0920-xxxx  
Exp. Date xx/xx/xxxx

Child's Name: \_\_\_\_\_ Child's teacher: \_\_\_\_\_

**Yes, I give permission for my child to have his/her teeth checked.**

**No, I do not give permission for my child to have his/her teeth checked.**

\_\_\_\_\_  
Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Name/title of school personnel receiving verbal consent from parent/caretaker

\_\_\_\_\_  
Signature of school personnel receiving verbal consent \_\_\_\_\_ Date received: \_\_\_\_\_

Public reporting burden of this collection of information varies from 431 to 2,570 hours with an estimated average of 1,183 hours per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

