

**Stoughton Public Schools  
Stoughton, Massachusetts 02072**

Dear Parents/Guardians:

The Stoughton Public Schools has an opportunity to participate in the Weekly Fluoride Rinse Program this year. The program will be coordinated and funded by the Massachusetts Department of Public Health Office of Oral Health. Our school nurse has been trained for this program and it will be offered to all Gibbons School fourth grade students. The program will begin the last week of October and last for twenty weeks.

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 % to 40 %. Under supervision of the school nurse, participating students will rinse their mouths with 10 ml (2 tsp) of 0.2 % neutral sodium fluoride solution for one minute each week. The solution is not swallowed and there are no adverse effects associated with this procedure.

This program will help improve the dental health of your child, although it will not take the place of regular dental check-ups and proper tooth care at home.

**Fluoride mouth rinse is beneficial. It is not meant as a substitute for any other fluoride your child may be getting, either by fluoridated water, from your dentist, or by prescription.**

Participation in the mouth rinse program is voluntary and there is no cost to you. We encourage you to allow your child to participate in this valuable health program.

**Your child can participate in this 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 a question about the program, you may call the school nurse at 781-344-7008 and select option 2.

Please sign the form below and return it to your child's teacher.

Sincerely,  
Gibbons School Nurse

.....  
 Yes, I want my child to participate in the Weekly Fluoride Rinse Program.  
 No, I do not want my child to participate in the Weekly Fluoride Rinse Program.

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Teacher

\_\_\_\_\_  
Room

\_\_\_\_\_  
Date