

2024–2025 Wisconsin Healthy Smiles Survey: Individual Opt-Out

By completing this form, I acknowledge that I do **not** want my student to participate in the 2024-2025 Wisconsin Healthy Smiles Survey.

Please submit this form to:

Student's Last Name: _____

Student's First Name: _____

Please check the following:

☐ No, I do not give my student permission to participate in the oral health screening.

SIGNATURE – Parent or Guardian

Date Signed

Print Name

