BRISTOL-BURLINGTON HEALTH DISTRICT

240 Stafford Avenue, Bristol, Connecticut 06010-4617
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SCHOOL DENTAL HEALTH PROGRAM K – 8th grade

Permission Form/School Year 2019 - 2020

Dear Parent(s)/ Legal Guardian(s):
As part of School Health Services, the Bristol-Burlington Health District (BBHD) offers a Dental Health Program. A child enrolled in this program will be offered dental cleanings, caries (cavity) risk assessment and fluoride treatments by our Registered Dental Hygienist (RDH). Research shows that young children can benefit greatly from dental care provided throughout the year. Therefore, we strongly encourage you to enroll your child in this program. There is no charge to the family for this service.

Student's Name: ________________________________ ___________________ Date of Birth:___________________ Grade:_________

Student's Address: ____ Student's School:________________________

Parent(s)/Guardian(s) Name(s): ____ Phone #:_________________________

____ YES, I DO* or ____ NO, I DO NOT give consent for my child to be treated in school and receive dental health services deemed necessary by the school Registered Dental Hygienist, including cleanings, a caries risk assessment & fluoride treatment.

____ ____ _______________
Parent/Legal Guardian Name Signature Date

*If you checked YES above, what type of dental insurance does your child have? ____Private ____HUSKY ____None

Student's Dental & Health History

Does your child have a Dentist? ___Yes ___No If yes, Dentist's Name:____
Child's last visit to Dentist_____/_____/_______ What procedures were performed on your child?

____Teeth cleaning ___X-Rays ____Fluoride treatment ___Fillings ____Other:________________________________
Does your child take any medications? ___Yes ___No If yes, please list them below:

____

Does your child have any allergies to medication, latex or other? ____Yes ____No
If yes, please list:____
Does your child have a disability and/or impairment? ___Yes ___No If yes, please describe:

____

Does your child have or ever had any of the following?

Asthma	___ Yes	___No	Cancer	___ Yes	___No	Blood Disorder	___ Yes	___No
Hepatitis	___ Yes	___No	Epilepsy	___ Yes	___No	Congenital Heart Defect	___ Yes	___No
HIV/AIDS	___ Yes	___No	Rheumatic Fever	___ Yes	___No	Heart Murmur	___ Yes	___No
Diabetes	___ Yes	___No	Tuberculosis	___ Yes	___No	Stomach, Liver or Kidney problems	___Yes	___No

Other health issues, concerns or conditions:____

Please check one for the following question and Sign Below

____ I DO or ____ I DO NOT give consent for the release and exchange of information between the school's Registered Dental Hygienist and your child's dentist and/or health care provider to assure your child's oral health needs are met in school.

____ ____ _______________
Parent/Legal Guardian Name Signature Date

Upon completion of this form, please return it to the School's Health Room.**
If you have questions, contact your school's Dental Hygienist