BRISTOL-BURLINGTON HEALTH DISTRICT

240 Stafford Avenue, Bristol, Connecticut 06010-4617
Tel. (860) 584-7682 • Fax (860) 584-3814 • www.bbhd.org

SCHOOL DENTAL HEALTH PROGRAM K – 8th grade

Permission Form/School Year 2021 - 2022

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 a cavity risk assessment, fluoride treatment and dental cleanings as deemed necessary by the School 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: _____/_____/________

Child's Grade:_________ Teacher:____

Student's Address: ____

Parent(s)/Guardian(s) Name(s): ____

Parent(s)/Guardian(s) Phone Numbers: ____

What type of dental insurance does your child have?________________________**None**______

If HUSKY: Provide Student's HUSKY Client or ID#:____

Student's Dental & Health History

Does your child have a Dentist? ___Yes ___No

Child's Dentist's Name & Phone #:____

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 them list below:

____

____

CONTINUE ON OTHER SIDE

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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 below:

____

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

Asthma	___ Yes	___No	Stomach, Liver or Kidney Problems	___ Yes	___No
Cancer	___ Yes	___No	Blood Disorder	___ Yes	___No
Hepatitis	___ Yes	___No	Convulsions/Epilepsy	___ Yes	___No
HIV/AIDS	___ Yes	___No	Rheumatic Fever	___ Yes	___No
Diabetes	___ Yes	___No	Congenital Heart Defect	___ Yes	___No
Tuberculosis	___ Yes	___No	Heart Murmur	___ 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 my child to be treated in school and receive dental health services deemed necessary by the school Registered Dental Hygienist, including dental cleanings, a cavity risk assessment, fluoride treatments.

_____ **I DO** **or** ____ **I DO NOT** **give** and exchange and release of information between the school's Registered Dental Hygienist, school staff and your child's health care provider to assure your child's health and education needs are met in school.

______________________________ ______________________________ __________

Parent/Legal Guardian Name **Signature** **Date**

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