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

Healthy People
Healthy Communities

SCHOOL DENTAL HEALTH PROGRAM K – 8th grade

Permission Form/School Year 2022 - 2023

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 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 then 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 for permission 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** consent for 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.**