BRISTOL-BURLINGTON HEALTH DISTRICT
240 Stafford Avenue, Bristol, Connecticut 06010-4617
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Public Health
Prevent. Promote. Protect.

Healthy People
Healthy Communities

SCHOOL DENTAL HEALTH PROGRAM K – 8th grade

Permission Form/School Year 2023 - 2024

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 Teacher:_____

Parent(s)/Guardian(s) Name(s): _____ Phone: _____

What type of dental insurance(s) does your child have? _____ HUSKY _____ None_____

If HUSKY please provide the client or ID#_____

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 Diabetes ___ Yes ___No

Epilepsy ___ Yes ___No Congenital Heart Defect ___ 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 cleanings, a caries risk assessment, fluoride treatment.

____ **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 Registered Dental Hygienist