



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 2020 - 2021

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: ____/____/____

Student's Address: _____

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

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

Child's Grade: _____ Teacher: _____

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



Public Health
Prevent. Promote. Protect.



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

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 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.