



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 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 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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stomach, Liver or Kidney Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blood Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Convulsions/Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| HIV/AIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Congenital Heart Defect | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> 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.****