Town of Fairfield
Fairfield, Connecticut 06824

Public Health Nursing
100 Mona Terrace

DENTAL PROGRAM

Phone: 203-256-3150
Fax: 203-256-3172

TO: Parent/Guardian
FROM: Town of Fairfield Director of Health

The Town of Fairfield Health Department provides dental screenings, teeth cleaning, caries risk assessment, and topical fluoride treatments by a Registered Dental Hygienist in our schools. The program is available to all students that have Husky insurance, or that meet income guidelines. Additionally, limited funding for eligible students is available for care by participating dentists for cavity detecting x-rays, and problems such as cavities. **For children with Husky Insurance: The Town of Fairfield Health Department has been approved by the State of Connecticut as a Husky/Medicaid/ Provider. Please include your child's 9-digit HUSKY ID number**.

If you wish to apply for a dental screening, cleaning, caries risk assessment, fluoride treatment, and/or dentist services for your child, please complete all of the requested information below and **RETURN IT TO YOUR CHILD'S SCHOOL NURSE AS SOON AS POSSIBLE. PLEASE COMPLETE ALL ITEMS.**

Puede solicitar este formulario en español en la enfermería de la escuela de su hijo.
Você pode solicitar este formulário em português no escritório da enfermeira da escola do seu filho.
يمكنك طلب هذا النموذج باللغة
مكتب ممرضة المدرسة

Dental Program Application

Child's Name: _____ School: _____ Grade/Class: _____
(Please print)

Address: _____

Does child have a heart problem or other medical condition that would impact receiving dental treatment?

_____ Yes _____ No

If yes, please explain: _____

Check all that apply: Child has:

_____ HUSKY Insurance: ID # _____

_____ Private dental insurance

_____ None of the above

Have you recently applied for HUSKY Insurance? _____ Yes _____ No

If you do not have Husky insurance, you must provide income information and sign the permission statement below. You will be notified of your eligibility.

- Family maximum annual adjusted gross income: $_____
- Number in household: _____

Please sign below:
I give my permission for the above-named child to receive a dental screening, teeth cleaning, caries risk assessment, and fluoride treatment by the dental hygienist in school if he/she is eligible for these services.

Parent/Guardian Signature _____ Date: _____

Daytime Telephone #: _____

(PLEASE RETURN THIS FORM TO THE SCHOOL NURSE AS SOON AS POSSIBLE)