ACT Government
Education

BONYTHON PRIMARY SCHOOL
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5 September 2019

KINDERGARTEN DENTIST VISIT
17 SEPTEMBER 2019

Dear Families,

We have the opportunity to engage with a local dental therapist in a dental health program. During Carolyn's visit she will provide a dental lesson and screenings. The aim is to teach children about the importance of dental care and to build their confidence and tolerance of someone looking in their mouth whilst in the familiarity of their school environment.

In the classroom session, Carolyn will cover the names and function of teeth, cleaning, tooth friendly foods and visiting a dental clinic.

Written consent from a parent or guardian is required if you would like your child's mouth checked. Consent forms are attached and can be submitted to your child's teacher before the visit. During the dental screen, disposable battery dental mirror lights are used to check the mouth for any signs of dental disease. Latex free gloves are used. This is an optional program as we understand some students may already be existing clients within A.C.T Health or the special needs paediatric dentist.

Following the dental screen, a letter will be sent home to parents with the results and followed up with a phone call for any urgent care. For those children requiring a follow up visit, an appointment can be made with the ACT Dental Health Program at your nearest convenient community health centre clinic or with your existing dental practitioner.

Kind Regards,

Amanda Hawkins
Kindergarten Team Leader

Carolyn Stroud
Dental Therapist
ACT Dental Health Program
Tuggeranong Health and Community Centre.
Carolyn.Stroud@act.gov.au

DIVISION OF SURGERY AND ORAL HEALTH
DENTAL HEALTH PROGRAM

DENTAL SCREENING PROGRAM CONSENT FORM

Please enter the personal details of child.

Surname	First Name	M/F	Date of Birth

Address: _____

Suburb: _____ **Postcode:** _____ **Email:** _____

Telephone: (Mobile) _____ **(Home)** _____ **(Work)** _____

Medical Condition/s:

I consent to my child listed above receiving a dental screening by the Dental Health Program.

_____ _____ _____

Name of Parent/ Guardian **Signature** **Date**

Privacy note: The information provided on this form will be used in connection with the child's dental screening. All information will be confidential.

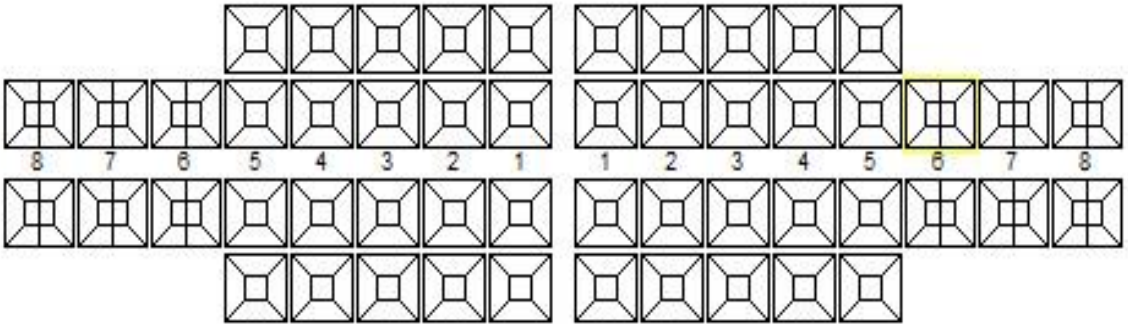
OFFICE USE ONLY: Oral health Assessment Result. School:_____

Code	Descriptor	Tick	Clinical Information	Time required
1.	Urgent Dental treatment			
2.	Dental Disease Present			
3.	Other Treatment Needs			
4.	No Treatment Needs			
	Provided oral health advice	○ **Diet** ○ **TB** ○ **Other**		

DT:	Date:

☐ **Data entered in Titanium**_____(date entered)

Dental Chart



CLINICAL NOTES:

Caries: _____
Perio: _____
Oral Hygiene: _____
Occlusion: _____
Compliance: _____
Engagement: _____
Verbal/Non-verbal: _____
Dental Lesson: _____

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