ST. VRAIN VALLEY SCHOOLS

academic excellence by design

Upcoming Dental Screening

Dear Parents and Guardians,

Thank you for your partnership as we continue to advance learning for all St. Vrain Valley students. Supporting student health and wellbeing is an important part of ensuring students have a productive and successful academic experience. Toward that end, St. Vrain Valley Schools works with a number of community partners to provide health and screening services for our students.

For more than 75 years the Sunshine Club in Longmont has focused on helping students of St. Vrain Valley Schools improve or maintain good dental health by working with local dentists to volunteer to screen students at their schools. The dental clinic is held in January and February each year and involves dentists, their assistants and Sunshine Club volunteers to screen all first through fifth grade who have not been seen by a dentist in the past 6 months and have parental permission to be examined.

After each clinic, notes will be sent home to the parents of all the students screened during the clinic telling them the dentist's findings and/or recommendations. Parents with a child that has urgent needs for dental care and qualify for Sunshine Club financial assistance will also receive the information they need to apply for continued support.

If you have any questions, please do not hesitate to contact Student Services at 303-772-7700.

SUNSHINE CLUB DENTAL SCREENING CLINIC PERMISSION SLIP

Good dental health habits are important and need to be established early in life. A free dental screening will be offered for students in your child's school in January or early February. **(1st – 5th grades only). For your child to be seen in the dental screening, this form must be submitted to the school. Please sign and return to your child's teacher by:_____.**

Dental Screening Clinic Date: _____School: _____

Student's Name: _____

Birth Date: _____ Grade: _____ Teacher: _____

I understand that the information regarding my child's dental health will be sent home with him/her following the dental clinic. My child has permission to be seen at the dental screening clinic.

Parent/Guardian_____ _____ _____
PRINT SIGNATURE DATE

Was your child seen by a dentist in the past six months? YES____NO_____ Dentist's name:_____

Does your child receive Medicaid? YES_____NO_____

Does your child have dental insurance of any kind? YES_____NO_____

Department of Student Services
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