

ORAL HEALTH ASSESSMENT VERIFICATION FORM

Effective January 1, 2007, California law (Education Code Section 49452.8) requires a dental check-up for all children entering a public school for the first time.

This assessment must be performed by a licensed California dental professional operating within their scope of practice. If your child has had an oral health examination within the last 12 months prior to entering school for the first time, that exam will meet the State's requirement. Please completed Section 1, have your child's dentist complete and sign Section 2 and return the form to your child's school nurse.

If your child has not had an oral assessment done within the last 12 months, your child's school nurse schedules an annual dental check-up at school which is performed by a local volunteer dentist during the months of February and March.

If you do not want your child to have the oral assessment done at school or by your child's dentist, you need to complete Section 3 of this form.

SECTION 1: Child's Information

(to be completed by the parent/guardian)

Child's name: _____ Birthdate: _____ Gender: M / F (circle one)

Address: _____
 _____ City _____ Zip Code _____

School Name: _____ Teacher Name/Grade: _____

Parent/Guardian Name: _____

Child's race/ethnicity (√ one) White Black/African American Hispanic/Latino
 American Indian Alaska Native Native Hawaiian/Pacific Islander
 Asian Multi-racial Unknown

SECTION 2: Oral Health Data Collection

(to be completed by a licensed California dental professional)

IMPORTANT NOTE: Consider each box separately. Mark each box.

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|------------------|--|---|--|
| Assessment Date: | <u>Caries Experience</u> (visible decay and and/or fillings present) <input type="checkbox"/> Yes <input type="checkbox"/> No | <u>Visible Decay Present:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No | <u>Treatment Urgency:</u> <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended (caries without pain or infection or child would benefit from sealants or further evaluation) <input type="checkbox"/> URGENT care needed (pain, infection, swelling or soft tissue lesions) |
|------------------|--|---|--|

_____ CA License Number _____ Date _____
 Licensed Dental Professional Signature

SECTION 3: Waiver of Oral Health Assessment Requirement

(to be completed by the parent/guardian)

Please excuse my child from the dental check-up because: Please check √ box that best describes the reason.

I am unable to find a dental office that will take my child's dental insurance plan. My child's dental insurance is:
 Medi-Cal/Denti-Cal Healthy Families Healthy Kids Other _____ None

I cannot afford a dental check-up for my child.
 I do not want my child to receive a dental check-up.
 Optional: other reasons my child could not get a dental check-up: _____

Signature of Parent/Guardian _____ Date _____

The law states school must keep student health information private. Your child's name will not be part of any report as a result of this law. This information may only be used for purposes relating to your child's health. If you have any questions, contact your child's school nurse.

Distribution of copies: **Original: Child's school health record**
 Copies: Parent/guardian
 CUSD Nursing Services