**Oral Health Assessment Form**

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by May 31 of his/her first year in public school. A California licensed dental professional operating within his scope of practice must perform the check-up and fill out Section 2 of this form. If your child had a dental check-up in the 12 months before he/she started school, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out Section 3.

**Section 1: Child’s Information (Filled out by parent or guardian)**

|  |  |  |  |
| --- | --- | --- | --- |
| Child’s First Name: | Last Name: | Middle Initial: | Child’s birth date: |
| Address:  | Apt.: |
| City: | ZIP code: |
| School Name: | Teacher: | Grade: | Child’s Sex:□ Male □ Female |
| Parent/Guardian Name: | Child’s race/ethnicity: □ White □ Black/African American □ Hispanic/Latino □ Asian  □ Native American □ Multi-racial □ Other\_\_\_\_\_\_\_\_\_\_\_ □ Native Hawaiian/Pacific Islander □ Unknown |

**Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional)**

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

|  |  |  |  |
| --- | --- | --- | --- |
| Assessment Date: | Caries Experience(Visible decay and/or fillings present)□ Yes □ No | Visible DecayPresent:□ Yes □ No | Treatment Urgency:□ No obvious problem found□ Early dental care recommended (caries without pain or infection;  or child would benefit from sealants or further evaluation)□ Urgent care needed (pain, infection, swelling or soft tissue lesions) |
| ***Licensed Dental Professional Signature CA License Number Date*** |

**Section 3: Waiver of Oral Health Assessment Requirement**

**To be filled out by parent or guardian asking to be excused from this requirement**

Please excuse my child from the dental check-up because: (Check the 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 plan 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:

**If asking to be excused from this requirement: ▶*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

 ***Signature of parent or guardian*** ***Date***

The law states schools 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 related to your child's health.  If you have questions, please call your school.

**Return this form to the school *no later than* May 31** of your child’s first school year.

*Original to be kept in child’s school record.*