

**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 their 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: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name:	Child's race/ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Multi-racial <input type="checkbox"/> Other _____ <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> 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:	<u>Caries Experience</u> (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)	
_____ <i>Licensed Dental Professional Signature</i>			_____ <i>CA License Number</i>	_____ <i>Date</i>
_____ <i>PRINTED Provider Name/Clinic Name</i>			_____ <i>Phone #</i>	_____ <i>Fax #</i>

**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.
- Other reasons my child did 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.*