

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by May 31 of their 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 they 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:	Caries Experience (Visible decay and/or fillings present) <input type="checkbox"/> Yes <input type="checkbox"/> No	Visible Decay Present: <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment Urgency: <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>

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)	
<input type="checkbox"/> I am unable to find a dental office that will take my child's dental insurance plan. My child's dental insurance plan is: <input type="checkbox"/> Medi-Cal/Denti-Cal <input type="checkbox"/> Other: _____ <input type="checkbox"/> None	
<input type="checkbox"/> I cannot afford an oral health screening for my child. <input type="checkbox"/> I do not want my child to receive an oral health screening. <input type="checkbox"/> Optional: other reasons my child could not get an oral health screening: _____	
Please sign if asking to waive Oral Health Assessment Requirement: _____	
<i>Signature of parent or guardian Date</i>	

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 contact your school office.

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.

County of San Diego, Health and Human Services Agency, Public Health Services, Maternal, Child, and Family Health Services
For more information, please call (619) 692-8808



School Entry Health Exam Requirement

Early and regular **health check-ups** can prevent, find, and treat many health problems before they become serious. That is why California has a **law** that says all children **must** have a health checkup within **18 months before first grade or up to 90 days after starting first grade**. Your child must also have certain immunizations, or shots, for school. Your doctor will be able to check your child's immunization record and see what shots are needed during the health checkup. Your doctor will complete this form. You must return this completed form to your child's school.

If you are not able to pay for this check-up, please call the County of San Diego Maternal Child and Family Health Services (MCFHS) to find out if your child is eligible for a health check-up at no-cost. MCFHS can also provide information on medical and dental insurance.

619-692-8808

PART I – TO BE FILLED OUT BY THE PARENT/GUARDIAN				
Child's Last Name:		First Name:		Middle Initial:
Birth Date (mm/dd/yyyy):			School Name:	
Home Address (Number, Street):			City:	Zip:
<input type="checkbox"/> I want the medical provider to complete Part II only.				
PART II – TO BE FILLED OUT BY THE MEDICAL PROVIDER				
Tests and Evaluations			Date of Exam	MEDICAL PROVIDER INFORMATION
Height _____ inches	Weight _____ lbs _____ ozs	BMI Percentile _____ %		
Health/Development History			Name, Address, and Telephone Number:	
Physical Examination				
Nutritional Evaluation				
Vision Screening				
Audiometric Screening				
Blood Test for Anemia				
Oral Health Screening				
Tuberculin (TB) Risk Assessment /Skin Test			Signature of Medical Professional / Date	
DOES CHILD HAVE A COMPLETED AND UPDATED YELLOW CALIFORNIA IMMUNIZATION RECORD? <input type="checkbox"/> Yes <input type="checkbox"/> No				
PART III – TO BE FILLED OUT BY THE MEDICAL PROVIDER				
<p>Other health information (optional): For child's welfare and with the permission of the parent or guardian, it is recommended that significant health information be shared with the school. <i>Please contact the school nurse if child needs help with medication at school.</i></p> <p><input type="checkbox"/> Parent requests Part III not to be filled out</p> <p><input type="checkbox"/> The examination revealed no conditions of importance to school or physical activity.</p> <p><input type="checkbox"/> Conditions that need further evaluation or that can affect school or physical activity are (please explain below)</p>				
WAIVER OF MEDICAL EXAMINATION				
<p>I have been told about the medical examination recommended by health professionals and required by State law. I have also been given information on no-cost medical examinations that my child may be eligible for, if such assistance is needed.</p> <p><input type="checkbox"/> I do not want my child to receive a medical examination</p> <p><input type="checkbox"/> I do want my child to receive a medical examination, but I am unable to get it because _____</p>				
_____ <i>Signature of Parent or Guardian</i>			_____ <i>Date</i>	

County of San Diego, Health and Human Services Agency, 3851 Rosecrans St., Ste. 522, San Diego, CA 92110
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