Oral Health Assessment Form

Keep this form with your child's immunization record (yellow card)

California law (Education Code Section 49452.8) states that 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/her scope of practice must perform the check-up and fill out Section 2 of this form. **If your child had a dental check-up within 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: _____ **Child's Last Name:** _____ **Middle Initial:** _____ **Child's Date of Birth:** _____

Address: _____ **City:** _____ **Zip Code:** _____

School Name: _____ **Teacher:** _____ **Grade:** _____ **Child's Sex (select one):** ☐ Male ☐ Female

Parent/Guardian Name: _____

Child's Race/Ethnicity (select one):
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ Native American ☐ More than one race
☐ Unknown ☐ Other (specify): _____

Section 2: Oral Health Information (Filled out by California licensed dental professional)

IMPORTANT NOTE: Consider each box separately – mark the appropriate field in **each** box.

Assessment Date: _____

Caries Experience/ Fillings present (select one): ☐ Yes ☐ No

Visible decay present (select one): ☐ Yes ☐ No

Treatment urgency (select one):
☐ 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:** _____

Provider/Clinic Name: _____ **Phone:** _____ **Fax:** _____

Section 3: Waiver of Oral Health Assessment Requirement (Filled out by parent or guardian asking to be excused from this requirement)

Please excuse my child from the dental check-up because (select one 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 (select one): ☐ Medi-Cal/Denti-Cal ☐ 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 reason (specify): _____

Please sign if asking to be excused from the oral health assessment requirement: _____
Signature **Date**

The law states that 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 related to your child's health. If you have any questions, please contact your school office.

Return this form to school by 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, 3851 Rosecrans St., Ste. 522, San Diego, CA 92110
For more information, please call (619) 692-8808

Child Health and Disability Prevention Program
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