|  |  |
| --- | --- |
| Parent’s/Guardian’s Name: | Race/Ethnicity: Asian Black/African American Hispanic/Latino Multi-racial Native American Native Hawaiian/Pacific Islander  White Unknown Other (*Please specify*)\_\_\_\_\_\_\_\_\_\_\_\_\_  |

## Oral Health Screening Form

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| --- | --- |
| Date of Screening |  |
| Level of Urgency |  |

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| --- |
| Section 2: Oral Assessment (Filled by California licensed dental professional) |
| 1. **Caries experience**
 |
| 1. Fillings present: Yes No
 | 1. Visible caries: Yes No

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| 1. **Treatment Urgency**
 |
|  **Level 1 -** No obvious problem found.Preventive care with complete oral evaluation recommended. |
|  **Level 2 -** Caries without pain or infection; and/or child would benefit from sealants or further evaluation. **Early Dental Care Recommended** |
|  **Level 3 –** Detected (select all that apply) pain infection swelling soft tissue lesions. **Urgent Care Needed**  |
| 1. **Other Findings**
 |
| Gingival problems: Yes No Orthodontic intervention indicated: Yes NoOther problem identified \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **Other Services provided**
 |
|  Fluoride Varnish Prohpylaxis Other services:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| Name of Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title of Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | License Number\_\_\_\_\_\_\_\_\_\_\_\_Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_ |

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| Section 3: Outreach and Care Coordination (To be filled by dental care coordinator or school nurse) |
| Parent/Guardian Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Languages Spoken\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sealant Consent: Positive Negative Not returned Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |