

Kentucky Dental Screening/Examination Form for School Entry August 2010

Kentucky law, KRS 156.160(i), requires proof of a dental screening or examination by a dentist, dental hygienist, physician, registered nurse, advanced registered nurse practitioner, or physician assistant. This evidence shall be presented to the school no later than January 1 of the first year that a five (5) or six (6) year old is enrolled in public school.

Student Name: _____ <div style="display: flex; justify-content: space-around; font-size: small;"> Last First Middle </div>		Student Race/Ethnicity: (Please check one) <div style="display: flex; flex-wrap: wrap; padding: 5px;"> <div style="width: 50%;"><input type="checkbox"/> 1 White</div> <div style="width: 50%;"><input type="checkbox"/> 5 American Indian/Alaska</div> <div style="width: 50%;"><input type="checkbox"/> 2 Black/African American</div> <div style="width: 50%;"><input type="checkbox"/> 6 Native Hawaiian/Pacific Islander</div> <div style="width: 50%;"><input type="checkbox"/> 3 Hispanic /Latino</div> <div style="width: 50%;"><input type="checkbox"/> 7 Multi-racial</div> <div style="width: 50%;"><input type="checkbox"/> 4 Asian</div> <div style="width: 50%;"><input type="checkbox"/> 9 Unknown</div> </div>	
Birth date: ____/____/____ Gender: <input type="checkbox"/> 0 Male <input type="checkbox"/> 1 Female		Screener's Name: _____	
Parent or Guardian: _____ <div style="display: flex; justify-content: space-around; font-size: small;"> Name Relationship </div>		Screener's Address: _____	
Address: _____ City: _____		Phone Number: _____ Screening Date: _____	
Phone Number: _____ School: _____		Screener's Signature: _____	
Date of Enrollment ____/____/____		_____	
Untreated Decay: (Check one) <div style="margin-top: 10px;"> <input type="checkbox"/> 0 No untreated cavities <input type="checkbox"/> 1 Untreated cavities </div>	Treated Decay: (Check one) <div style="margin-top: 10px;"> <input type="checkbox"/> 0 No treated cavities <input type="checkbox"/> 1 Treated cavities </div>	Professional affiliation: (Please check one) <div style="margin-top: 10px;"> <input type="checkbox"/> Dentist <input type="checkbox"/> Dental Hygienist <input type="checkbox"/> Physician Assistant <input type="checkbox"/> LHD Registered Nurse with KIDS Smiles training <input type="checkbox"/> ARNP <input type="checkbox"/> Physician </div>	
Pattern of Early Childhood Cavities: (Check one) <div style="margin-top: 10px;"> <input type="checkbox"/> 0 No Early Childhood Cavities <input type="checkbox"/> 1 Early Childhood Cavities Present </div>	Treatment Urgency: (Check one) <div style="margin-top: 10px;"> <input type="checkbox"/> 0 No obvious problem <input type="checkbox"/> 1 Early dental care needed <input type="checkbox"/> 2 Urgent care needed NOTE: Comment required if marked. </div>	Comments: _____ _____	