

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.

<p>Student Name: _____ <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> Last First Middle </div> </p> <p>Birth date: ____/____/____ Gender: <input type="checkbox"/> 0 Male <input type="checkbox"/> 1 Female</p> <p>Parent or Guardian: _____ <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> Name Relationship </div> </p> <p>Address: _____ City: _____</p> <p>Phone Number: _____ School: _____</p> <p align="center">Date of Enrollment ____/____/____</p>		<p>Student Race/Ethnicity: (Please check one)</p> <div style="display: flex; flex-wrap: wrap;"> <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>
<p>Untreated Decay: (Check one)</p> <p><input type="checkbox"/> 0 No untreated cavities</p> <p><input type="checkbox"/> 1 Untreated cavities</p>	<p>Treated Decay: (Check one)</p> <p><input type="checkbox"/> 0 No treated cavities</p> <p><input type="checkbox"/> 1 Treated cavities</p>	<p>Screener's Name: _____</p> <p>Screener's Address: _____</p> <p>_____</p> <p>Phone Number: _____ Screening Date: _____</p> <p>Screener's Signature: _____</p>
<p>Pattern of Early Childhood Cavities: (Check one)</p> <p><input type="checkbox"/> 0 No Early Childhood Cavities</p> <p><input type="checkbox"/> 1 Early Childhood Cavities Present</p>	<p>Treatment Urgency: (Check one)</p> <p><input type="checkbox"/> 0 No obvious problem</p> <p><input type="checkbox"/> 1 Early dental care needed</p> <p><input type="checkbox"/> 2 Urgent care needed <small>NOTE: Comment required if marked.</small></p>	<p>Professional affiliation: (Please check one)</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> Dentist</div> <div style="width: 50%;"><input type="checkbox"/> Dental Hygienist</div> <div style="width: 50%;"><input type="checkbox"/> Physician Assistant</div> <div style="width: 50%;"><input type="checkbox"/> LHD Registered Nurse with KIDS Smiles training</div> <div style="width: 50%;"><input type="checkbox"/> ARNP</div> <div style="width: 50%;"><input type="checkbox"/> Physician</div> </div>
<p>Comments:</p> 		