

Kindergarten Only

OFO/DSS

Kentucky Dental Screening/Examination Form for School Entry

KDESHS005

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.

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|--|---|---|
| Student Name: _____ Last First Middle | | Test Type (check one) <input type="checkbox"/> Screening <input type="checkbox"/> Exam |
| Birth date: ____/____/____ Gender: <input type="checkbox"/> 0 Male <input type="checkbox"/> 1 Female | | Screener's Name: _____ Screener's Address: _____ Phone Number: _____ Screening Date: _____ Screener's Signature: _____ Professional affiliation: (Please check one) <input type="checkbox"/> Dentist <input type="checkbox"/> Dental Hygienist <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Registered Nurse with training <input type="checkbox"/> APRN <input type="checkbox"/> Physician |
| Parent or Guardian Name: _____ Relationship _____ Address: _____ City: _____ Phone Number: _____ School: _____ Date of Exam/Screening ____/____/____ | | |
| Untreated Decay: (Check one) <input type="checkbox"/> 0 No untreated cavities <input type="checkbox"/> 1 Untreated cavities | Treated Decay: (Check one) <input type="checkbox"/> 0 No treated cavities <input type="checkbox"/> 1 Treated cavities | |
| Pattern of Early Childhood Cavities: (Check one) <input type="checkbox"/> 0 No Early Childhood Cavities <input type="checkbox"/> 1 Early Childhood Cavities Present | Treatment Urgency: (Check one) <input type="checkbox"/> 0 No obvious problem <input type="checkbox"/> 1 Early dental care needed <input type="checkbox"/> 2 Referral for Urgent Care NOTE: Comment required if marked. | |
| Comments: _____ | | _____ |