



Pequannock Township School District

Office of the Superintendent

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Dr. Michael Portas, Superintendent of Schools

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Dear Parents and Guardians of Preschool and Kindergarten Students:

It is our intent to promote oral health care which can affect student learning. We are requesting that the oral health assessment form be completed and returned with the medical registration packet. Tooth decay (or cavities) is the number one chronic childhood disease in America. Tooth decay is preventable with good oral hygiene and dental visits. One alarming statistic is that 51 million school hours are lost each year to untreated cavities. Young children who suffer from oral disease can have decreased appetite, inattentiveness, and distractibility caused by pain or infection.

Please have your child visit a dentist to ensure preventable disease. The NJ Dental Association offers an online find-a-dentist resource at www.njda.org.

Thank you for your support in keeping our students healthy to optimize learning.

Sincerely,

Pequannock Township Elementary School Nurses

ORAL HEALTH ASSESSMENT FORM

The New Jersey Children's Oral Health Education Program is administered by the New Jersey Department of Health. Program activities take place throughout the State with emphasis in areas of high need/high risk.

SECTION 1: Child's Information (completed by parent/guardian)

Child's Last Name:	First Name:	Child's Date of Birth:
Address:		
City/Zip Code:		
Child's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Parent/Guardian Name:	

SECTION 2: Oral Health Data Collection (completed by a licensed dental professional)

IMPORTANT NOTE: Consider each box separately. Mark each box:

Dental Examination Date:	Caries Experience - Restorations Present: <input type="checkbox"/> Yes <input type="checkbox"/> No	Visible Decay Present: <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment Urgency: <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) <input type="checkbox"/> Urgent care needed (pain, infection, swelling or soft tissue lesions)
Oral Hygiene: ___ Unsatisfactory ___ Satisfactory ___ Above Average			
_____ <i>Licensed Dental Professional Signature</i> <i>NJ License Number</i> <i>Date</i>			

SECTION 3: Waiver of Oral Health Assessment Requirement

To be filled out by parent/guardian asking to be excused from this requirement

Please excuse my child from the dental check-up because: (Check the box 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: _____

I cannot afford a dental check-up for my child.

I do not want my child to receive a dental check-up.

Optional: Other reasons my child could not get a dental check-up: _____

If asking to be excused from this requirement: _____

Signature of Parent/Guardian

Date