DENTON INDEPENDENT SCHOOL DISTRICT
Brooke Rushing, BSN, RN
Registered School Nurse
brushing2@dentonisd.org
Ann Windle School for Young Children
901 Audra Lane
Denton, Texas 76209
Phone: 940-369-3906
Fax: 940-304-3446

DENTAL VISIT FOR NEW AND RETURNING STUDENTS 2026-2027

RE: Dental Visit Form

WHO: All returning and new students planning to participate in the Head Start Program in the 2026-2027 year.

WHAT: Dental visit form given to your dentist.

WHERE: The **completed** dental visit form is **required at the door** prior to continuing the enrollment process. If your child has not seen the dentist within the last six months, schedule an appointment for a visit **before your appointment** date and the fall rush. If the dental visit form is not completed by the date and time of the assessment, your child can be placed back on the priority list. Remember to have the dentist to sign your form. There are **no exceptions**.

GIVEN TO: Nurse, Brooke Rushing (940) 369-3906

QUESTIONS: Please direct all questions to our nurse, family service assistant and social worker.

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Head Start Oral Health Form—Children

Patient Information

Child's name | Date of birth | Parent's/guardian's name | Phone number

Address | City | State | Zip code

This practice is the child's dental home: ☐ Yes ☐ No

Current Oral Health Status

Does the child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination: ☐ Yes ☐ No
X-rays: ☐ Yes ☐ No
Risk assessment: ☐ Yes ☐ No
Cleaning: ☐ Yes ☐ No
Fluoride varnish: ☐ Yes ☐ No
Dental sealants: ☐ Yes ☐ No

Counseling/Anticipatory Guidance

☐ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

(Please specify specialist)

Restorative/Emergency Care

Fillings: ☐ Yes ☐ No
Crowns: ☐ Yes ☐ No
Extractions: ☐ Yes ☐ No
Emergency care: ☐ Yes ☐ No
Other: *(Please specify)*

Future Oral Health Care Services

All treatment completed: ☐ Yes ☐ No Next recall date: ____ / ____ (month/year)

More appointments needed for treatment? ☐ Yes ☐ No

If yes: Approximate number of appointments needed: ____ Next appointment: Date: ____ Time: ____

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* | Phone number | Fax number

Practice name | Address

Provider signature | Date of service

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