

# 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.

<b>Student Name:</b> _____ <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Last</span> <span>First</span> <span>Middle</span> </div>		<b>Student Race/Ethnicity:</b> (Please check one) <div style="display: flex; flex-wrap: wrap; font-size: small;"> <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		<b>Screener's Name:</b> _____ Screener's Address: _____ _____ Phone Number: _____ Screening Date: _____ _____ Screener's Signature: _____	
Parent or Guardian: _____ <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Name</span> <span>Relationship</span> </div>		<b>Professional affiliation:</b> (Please check one) <div style="display: flex; flex-wrap: wrap; font-size: small;"> <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>	
Address: _____      City: _____  Phone Number: _____      School: _____  Date of Enrollment ____/____/____			
<b>Untreated Decay:</b> (Check one) <div style="margin-top: 10px;"> <input type="checkbox"/> 0 No untreated cavities  <input type="checkbox"/> 1 Untreated cavities             </div>	<b>Treated Decay:</b> (Check one) <div style="margin-top: 10px;"> <input type="checkbox"/> 0 No treated cavities  <input type="checkbox"/> 1 Treated cavities             </div>		
<b>Pattern of Early Childhood Cavities:</b> (Check one) <div style="margin-top: 10px;"> <input type="checkbox"/> 0 No Early Childhood Cavities  <input type="checkbox"/> 1 Early Childhood Cavities Present             </div>	<b>Treatment Urgency:</b> (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>	<b>Comments:</b>	