

Kentucky Dental Screening/Examination Form for School Entry

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: _____ <div style="display: flex; justify-content: space-around; font-size: small;"> Last First Middle </div> | | Student Race/Ethnicity: (Please check one) <div style="display: flex; flex-wrap: wrap; padding: 5px;"> <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 | | Screener's Name: _____ Screener's Address: _____ _____ Phone Number: _____ Screening Date: _____ | |
| Parent or Guardian: _____ <div style="display: flex; justify-content: space-around; font-size: small;"> Name Relationship </div> | | Screener's Signature: _____ | |
| Address: _____ City: _____ | | Professional affiliation: (Please check one) <div style="display: flex; flex-wrap: wrap; padding: 5px;"> <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> | |
| Phone Number: _____ School: _____ | | Comments: | |
| Date of Enrollment ____ / ____ / ____ | | | |
| Untreated Decay: (Check one) <div style="padding: 5px;"> <input type="checkbox"/> 0 No untreated cavities <input type="checkbox"/> 1 Untreated cavities </div> | Treated Decay: (Check one) <div style="padding: 5px;"> <input type="checkbox"/> 0 No treated cavities <input type="checkbox"/> 1 Treated cavities </div> | | |
| Pattern of Early Childhood Cavities: (Check one) <div style="padding: 5px;"> <input type="checkbox"/> 0 No Early Childhood Cavities <input type="checkbox"/> 1 Early Childhood Cavities Present </div> | Treatment Urgency: (Check one) <div style="padding: 5px;"> <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> | | |