# 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.**

**Student Name:** _____
Last First Middle

Birth date: ____/____/____ Gender: ☐ 0 Male ☐ 1 Female

Parent or Guardian: _____
Name Relationship

Address: _____ City: _____

Phone Number: _____ School: _____

Date of Enrollment ____/____/____

**Student Race/Ethnicity:** (Please check one)

☐ I White
☐ 2 Black/African American
☐ 3 Hispanic /Latino
☐ 4 Asian
☐ 5 American Indian/Alaska
☐ 6 Native Hawaiian/Pacific Islander
☐ 7 Multi-racial
☐ 9 Unknown

**Screener's Name:** _____

Screener's Address: _____

_____

Phone Number: _____ Screening Date: _____

Screener's Signature: _____

**Professional affiliation:** (Please check one)

☐ Dentist
☐ Dental Hygienist
☐ Physician Assistant
☐ LHD Registered Nurse with KIDS Smiles training
☐ ARNP
☐ Physician

**Untreated Decay:** (Check one)

☐ 0 No untreated cavities
☐ 1 Untreated cavities

**Treated Decay:** (Check one)

☐ 0 No treated cavities
☐ 1 Treated cavities

**Pattern of Early Childhood Cavities:** (Check one)

☐ 0 No Early Childhood Cavities
☐ 1 Early Childhood Cavities Present

**Treatment Urgency:** (Check one)

☐ 0 No obvious problem
☐ 1 Early dental care needed
☐ 2 Urgent care needed
NOTE: Comment required if marked.

**Comments:**