	Absent		Absent		Uncooperative ☐ LR		Withdrawn
	Absent		Absent		Uncooperative ☐ LR		Transfer Site

DENTAL EVALUATION AND FLUORIDE VARNISH FORM

SECTION 1: TO BE COMPLETED DURING ENROLLMENT **PLEASE PRINT INFORMATION BELOW**

General Information

Child Name: ______________________ Child ID: __________ Head Start Center: ______________
Home Address: ______________________ City: ____________ State: ____________ Zip Code: ______
PA/FSW: Name: ______________________ PA/FSW Phone No.: ______________________
Date of Birth: _______/_______/_______ Gender: ☐Male ☐Female Teacher Name/Classroom No.: ______________
Child's Race/Ethnicity: ☐Hispanic ☐Non Hispanic/White ☐Black/African American ☐Multi Racial ☐Asian ☐American Indian/Alaska Native ☐Native Hawaiian/Pacific Islander ☐Other, specify: ______________________

Dental History

Does your child have dental insurance? ☐Yes ☐No If yes, name of insurance: ______________________
Check the appropriate box if your child has: ☐CHIP ☐Medicaid If yes, please list card no.: ______________
Name of dentist/dental home/clinic: ______________________ Phone Number: ______________
How often does your child visit the dentist? ☐Every 3-4 months ☐Every 6-12 months ☐Not Regularly ☐Never
Do you brush your child's teeth daily with fluoridated toothpaste? ☐Yes ☐No
Has your child ever had a cavity? ☐Yes ☐No
List any problems with your child's teeth, gums, or mouth: ______________________

Health History

Has your child ever had any serious health problems? ☐Yes ☐No If yes, please explain: ______________________
____
Does your child have any allergies to food or medications? ☐Yes ☐No If yes, please list: ______________________

Consent for Participation

The information in this consent form is given so that you will be informed about the dental services your child will receive through the Head Start Oral Health Prevention Program. Services offered through the program do not take place of dental services provided through your private dentist or community clinic. San Antonio Metropolitan Health District (SAMHD) will assist families in identifying a dental home if necessary.

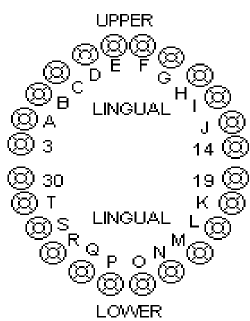
☐**Yes.** I give permission for my child to take part in the Head Start Oral Health Prevention Program, which includes a limited oral evaluation and a fluoride varnish application twice throughout the school year. I understand that a dentist from the City of San Antonio Metropolitan Health District (SAMHD) will perform a limited oral evaluation and provide me a dental referral of my child's dental status. Under the supervision of the dentist, I give permission for my child to receive an application of fluoride varnish **free of charge** provided by SAMHD. Fluoride varnish is a simple, painless dental treatment that has been proven to be effective in preventing tooth decay in children. I have been notified that my child's health information will be kept confidential and that I may review the SAMHD HIPAA policy by visiting http://www.sanantonio.gov/health website or may request a copy by calling 210. 207. 8841.

☐**No.** I do not want my child to take part in the Head Start Oral Health Prevention Program. [ ] No Consent

(PLEASE PRINT NAME) Parent/Guardian | ______________________________

Parent/Guardian Signature ______________ Phone **No.** ______________ **Date** ______________

SECTION 2: FALL DENTAL EVALUATION AND TREATMENT RECORD | THIS SECTION IS COMPLETED BY SAMHD



Fall

I certify that I have completed the services listed above

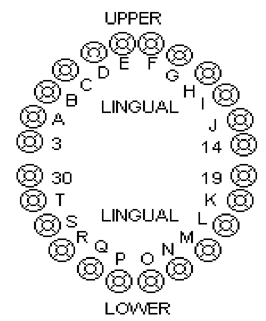
√	Services Provided	Code	Date of Service	Provider Initials
	Limited Oral Evaluation	Fall		
	Fluoride Varnish	Fall		
	Limited Oral Evaluation	Spring		
	Fluoride Varnish	Spring		

FINDINGS OF FALL EVALUATION

☐EARLY CHILDHOOD CARIES | Maxillary Arch (#C – #H)
☐CARIES EXPERIENCE | Treated or Untreated decay
☐CLASS ONE | Urgent, Needs attention immediately
☐CLASS TWO | Needs attention soon
☐CLASS THREE | No obvious signs of dental disease

ORAL HEALTH SUMMARY

☐**COMPLETE**
No treatment needed
Child has dental home
☐**NOT COMPLETE**
Treatment needed
Needs dental home



Spring

Dentist Signature: ______________________________ **Date:** ______________

SECTION 3: SPRING DENTAL EVLAUATION AND TREATMENT RECORD | THIS SECTION COMPLETED BY SAMHD

FINDINGS OF SPRING DENTAL EVALUATION

☐ Treatment appears to be completed
☐ Treatment appears to be in progress
☐ No signs that treatment has been initiated
☐ EARLY CHILDHOOD CARIES| Maxillary Arch (#C – #H)
☐ CARIES EXPERIENCE | Treated or Untreated decay

CURRENT ORAL HEALTH STATUS: ☐Class I ☐Class II ☐Class III

Progress Notes: ______________________________
____
____
____
____

Dentist Signature: ______________________________ **Date:** ______________