Kindergarten Oral Health Assessment Form

California law (*Education Code* Section 49452.8) says every child must have a dental check-up (assessment) by May 31st of his/her first year in public school. A California licensed dental professional must do the check-up and fill out Section 2 of this form. If your child had a dental check-up in the last 12 months, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out the separate Waiver of Oral Health Assessment Requirement Form.

This assessment will let you know if there are any dental problems that need attention by a dentist. This assessment will also be used to evaluate our oral health programs. Children need good oral health to speak with confidence, express themselves, be healthy and, ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of California's children.

Section 1: Child's Information (Filled out by parent or guardian)

Child's First Name:	Last Name:	Middle Initial:	Child's Birth Date: MM – DD – YYYY
Address:			Apt.:
City:			ZIP Code:
School Name:	Teacher:	Grade:	Year child starts kindergarten: Y Y Y Y
Parent/Guardian First Name:	Parent/Guardian Last Name:		Child's Gender: ☐ Male ☐ Female

Child's Race/Ethnicity:		
	☐ White	☐ Native American
	☐ Black/African American	☐ Multi-racial
	☐ Hispanic/Latino	☐ Native Hawaiian/Pacific Islander
	☐ Asian	☐ Unknown
	☐ Other (please specify)	

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Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional)

IMPORTANT NOTE: Consider each box separately. Mark each box.

Assessment Date: MM – DD – YYYY	Untreated Decay (Visible Decay Present) ☐Yes ☐No	*Caries Experience (Visible decay and/or fillings present) ☐Yes ☐No

Treatment Urgency:

◯ **No obvious problem found**

◯ **Early dental care recommended** (caries without pain or infection; or child would benefit from sealants or further evaluation)

◯ **Urgent care needed** (pain, infection, swelling or soft tissue lesions)

_____	_____	MM – DD – YYYY _____
Licensed Dental Professional Signature	***CA License Number***	***Date***

*Check "Yes" for Caries experience if there is presence of untreated decay or fillings
Check "No" for Caries experience if there is no untreated decay and no fillings

Section 3: Follow-up to Urgent Care (Filled out by entity responsible for follow up)

Parent notified that child has urgent dental care need on: MM – DD – YYYY
A follow-up appointment for this child has been scheduled for: MM – DD – YYYY
Did child receive needed treatment? ◯ **Yes** ◯ **No** (If no, entity responsible for follow-up will be encouraged to check back in with parent) ◯ **I don't know**

The law states schools must keep student health information private. Your child's name will not be part of any report as a result of this law. This information may only be used for purposes related to your child's health. If you have questions, please call your school.

Return this form to the school *no later than* May 31st of your child's first school year.

Original to be kept in child's school record.

County of San Diego Health and Human Services Agency, Public Health Services,
Maternal, Child, and Family Health Services
For more information, please call (619) 692-8858

Updated 12/2023

Clear Form

Waiver of Kindergarten Oral Health Assessment Requirement

Please fill out this form if you need to excuse your child the oral health assessment requirement. Sign and return this form to the school where it will be kept confidential.

Section 1: Child's Information (Filled out by parent or guardian)

Child's First Name:	Last Name:	Middle Initial:	Child's Birth Date: MM – DD – YYYY
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Year child starts kindergarten: Y Y Y Y
Parent/Guardian First Name:	Parent/Guardian Last Name:		Child's Gender: ◯ Male ◯ Female

Child's Race/Ethnicity:

- ◯ White
- ◯ Black/African American
- ◯ Hispanic/Latino
- ◯ Asian
- ◯ Other (please specify)
- ◯ Native American
- ◯ Multi-racial
- ◯ Native Hawaiian/Pacific Islander
- ◯ Unknown

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Section 2: To be filled out by parent or guardian ONLY IF asking to be excused from this requirement

Please excuse my child from the assessment because (check the box that best describes the reason):	
☐	I cannot find a dental office that will take my child's dental insurance plan. My child's dental insurance plan is: ☐ Medi-Cal ☐ Covered California ☐ Healthy Kids ☐ None ☐ Other:_____
☐	I cannot afford an assessment for my child.
☐	I cannot find the time to get to a dentist (e.g., cannot get the time off from work, the dentist does not have convenient office hours).
☐	I cannot get to a dentist easily (e.g., do not have transportation, located too far away).
☐	I do not believe my child would benefit from an assessment.
☐	Other (please specify the reason not listed above for why you are seeking a waiver of this assessment for your child): _____ _____

If asking to be excused from this requirement:

▶_____ MM – DD – YYYY

Signature of parent or guardian ***Date***

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Return this form to the school *no later than* May 31 of your child's first school year.

Original to be kept in child's school record.