**OAS/DSS** **Kentucky Dental Screening/Examination Form for School Entry** **KDESHS005**

**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 Exam/Screening _____/_____/_____

Test Type (check one)

☐ Screening

☐ Exam

**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

☐ APRN ☐ 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 Referral for Urgent Care
NOTE: Comment required if marked.

**Comments:**