

**School Town of Highland  
Oral Health Assessment Form**

Indiana law states your child must have a dental check-up his/her first year in public school. A Indiana licensed dental professional operating within his scope of practice must perform the check-up and fill out Section 2 of this form. If your child had a dental check-up in the 12 months before he/she started school, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out Section 3.

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

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Child's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name:	Phone Number:		

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

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

Assessment Date:	Caries Experience (Visible decay and/or fillings present) <input type="checkbox"/> Yes <input type="checkbox"/> No	Visible Decay Present: <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment Urgency: <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) <input type="checkbox"/> Urgent care needed (pain, infection, swelling or soft tissue lesions)
<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> <i>Licensed Dental Professional Signature</i>		<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> <i>Date</i>	

**Section 3: Waiver of Oral Health Assessment Requirement**

To be filled out by parent or guardian asking to be excused from this requirement

Please excuse my child from the dental check-up because: (Check the box that best describes the reason)

- I am unable to find a dental office that will take my child's dental insurance plan.
- I cannot afford a dental check-up for my child.
- I do not want my child to receive a dental check-up.
- Other reason my child could not get a dental check-up: \_\_\_\_\_

If asking to be excused from this requirement:

\_\_\_\_\_ *Signature of parent or guardian*

\_\_\_\_\_ *Date*