CAP AGENCY
COMMUNITY ACTION PARTNERSHIP
SERVING SCOTT CARVER & DAKOTA COUNTIES

Head Start

May return via fax at:
651-322-3555

Dental Exam Form
Oral Health Form

1302.42(b)(i)

CHILD'S NAME	DATE OF BIRTH	CLASSROOM

Oral Health Care Services Delivered During Visit

***Date of Service:** _____ ***

Diagnostic/Preventative Services:
Which of the following did the child receive during the date of service listed above?
☐ Examination
☐ X-Rays
☐ Risk Assessment
☐ Prophylaxis/Cleaning
☐ Fluoride Varnish
☐ Sealant
☐ Other – Describe:

Counseling/Anticipatory Guidance
☐ Yes ☐ No

Referral to Specialty Care
☐ Yes ☐ No
Please specify specialist:

Restorative/Emergency Care
Which of the following did the child receive during the date of service listed above?
Fillings: ☐ Yes ☐ No
Silver Diamine Fluoride: ☐ Yes ☐ No
Crowns: ☐ Yes ☐ No
Extractions: ☐ Yes ☐ No
Emergency Care: ☐ Yes ☐ No
Other – Describe: ☐ Yes ☐ No

☐ No Restorative/Emergency Care

Current Oral Health Status

Does the child have any teeth with untreated decay?
☐ Yes (decay present) ☐ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crown, or extractions?
☐ Yes ☐ No

Are there any additional treatment needs?
☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

***Is the child up to date on a schedule of age-appropriate oral health care?
☐ **Yes** ☐ **No**

Future Oral Health Care Services

***All treatment completed: ☐ Yes ☐ No

Next recall date: Date: _____ Time: _____

More appointments needed for treatment: ☐ Yes ☐ No
If yes: Approximate number of appointments needed ____

Next Appointment: Date: _____ Time: _____

Additional Information for Parents or Head Start Staff

Oral Health Provider's Contact Information and Signature

Provider Name (Print):	Clinic Name/Address (Stamp acceptable)
Provider Signature:	
Date Form Completed:	
Phone Number:	

Parent – Sign below: I hereby give my permission to the Provider/Clinic listed above to release information regarding the dental care provided to my child to CAP Agency Head Start. I reserve the right to revoke my permission at any time and this release will automatically expire one year after the date of my signature.

_____ _____
Parent/Guardian Signature Date

Shakopee CAP Office:
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