Kindergarten Oral Health Assessment (KOHA) Form: San Mateo County

California law (*Education Code* Section 49452.8) says every child enrolled in kindergarten in a public school, and any child enrolled in first grade *who did not attend public school the previous year*, must have a dental check-up (assessment). Transitional kindergartners can also complete the assessment. It should be turned in at the beginning of the school year. A California licensed dental professional must do the check-up and fill out **Sections 2 and 3** of this form. If your child had a dental check-up in the last 12 months, ask your dentist to fill out Sections 2 and 3. To find a dental provider in San Mateo County, visit: www.smchealth.org/accessing-oral-health-care. 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, and poorer social relationships. Thank you for supporting the health and well-being of California's children.

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

Child's First and Last Name: _____ **Middle Initial:** _____

Child's Birth Date: _____

Address (include Apt. if applicable): _____

City: _____ **Zip Code:** _____

School Name: _____

Teacher Name: _____ **Grade:** _____

Year child starts kindergarten: _____

Parent/Guardian First and Last Name: _____

Child's Gender: ☐ Boy ☐ Girl ☐ Nonbinary

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

Dental Home Information:

What is your child's dental insurance?

☐ Health Plan of San Mateo Dental (HPSM Dental) ☐ Kaiser Foundation Health Plan (Kaiser)
☐ Other: _____
☐ None

How many times a year does your child visit the dentist? ☐ Once ☐ Twice ☐ More than twice

Has your child visited the **same** dentist at least once a year for the past two years in a row? ☐ Yes ☐ No

Dental clinic name: _____ Dental clinic city: _____

Dentist name: _____ Dentist phone number: _____

Section 2: Oral Health Screening Assessment

Filled out by a California licensed dental professional. IMPORTANT NOTE FOR DENTAL PROVIDER: *Caries experience is both past treatment (e.g., fillings, crowns)* ***and /or*** *untreated decay at the present time (e.g., untreated cavities). Every child with untreated decay automatically also has caries experience for the purposes of this assessment.*

Assessment date:_____

Assessment Location: *(e.g. school, dental clinic, community event)****:***_____

Untreated decay *(Visible decay, untreated cavities):*

☐ Yes *(If "Yes," caries experience below is automatically also "Yes")* ☐ No

Caries Experience *(Untreated decay and/or past treatment, e.g. fillings, crowns):*

☐ Yes ☐ No

Treatment Urgency *(check* ***only one*** *of the 3 options provided below).*
If "Urgent care needed" is checked, complete Section 3 below. ***Do not*** *complete Section 3 if "No obvious problem found" or "Early dental care recommended" is checked.*

- ☐ **1. No obvious problem found**
- ☐ **2. Early dental care recommended** *(Check all that apply).*
  - ☐ Caries without pain or infection
  - ☐ Child would benefit from sealants
  - ☐ Child would benefit from further evaluation
- ☐ **3. Urgent care needed*** *(Check all that apply. Then complete as much of Section 3 below as possible).*
  - ☐ Pain
  - ☐ Infection
  - ☐ Swelling
  - ☐ Soft tissue lesions

***Section 3: Follow up *only for children with "Urgent care needed"* marked under "Treatment Urgency" above.** *(Dental provider fills out as much as known and signs. School staff/ other individual responsible for additional follow-up fills out rest of Section 3).*

Parent/caregiver notified child has urgent dental care needs on (date): _____

Follow-up appointment for child with urgent dental care needs scheduled for (date):_____

Child with urgent dental care needs received needed treatment *(Check* ***only one*** *of the options below).*
If "No" or "I Don't Know," the individual responsible for follow-up is encouraged to contact the parent/caregiver to assist in getting the child to care, and to confirm the child received needed treatment.

- ☐ Yes
- ☐ No*
- ☐ I Don't Know*

Licensed dental professional signature	***CA License Number***	***Date***

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 form to the school *no later* than by the end of your child's first school year.**

Original to be kept in child's school record.

Formulario de la evaluación de salud bucal para alumnos del kínder (Kindergarten): Condado de San Mateo

Kindergarten Oral Health Assessment Form: San Mateo County

La ley de California (Sección 49452.8 del Código de Educación) establece **que todos los alumnos del kínder (Kindergarten) inscritos en una escuela** *pública y cualquier niño inscrito en primer grado que no haya asistido a la escuela pública el año anterior,* **deberán realizarse un chequeo dental (evaluación)**. Los estudiantes de kindergarten de transición (TK) también pueden completar la evaluación. Debe ser entregado a la escuela **al comienzo del año escolar**. Un profesional dental autorizado de California debe realizar la evaluación y completar las secciones 2 y 3 de este formulario. Si su hijo tuvo una evaluación dental en los últimos 12 meses, pida a su dentista que complete la sección 2 y la sección 3. Para encontrar un proveedor dental en el condado de San Mateo, visite: www.smchealth.org/accessing-oral-health-care. Si no puede obtener una evaluación dental para su hijo, llene el formulario de exención del requisito de evaluación de salud bucal por separado.

Esta evaluación le permitirá saber si hay algún problema dental que necesite atención por parte de un dentista. Esta evaluación también se usará para evaluar nuestros programas de salud bucal. Los niños necesitan una buena salud bucal para hablar con seguridad, expresarse, y estar sanos y listos para aprender. La mala salud bucal ha estado relacionada con un menor desempeño escolar, malas relaciones sociales y menos éxito en el futuro. Por esta razón, le agradecemos que contribuya a la salud y el bienestar de los niños de California.

Sección 1: Información del menor (debe ser completada por el padre, la madre o el tutor)

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

Nombre y Apellido del Menor (*Child's First and Last Name*)**:** _____
Inicial del segundo nombre: *(Middle Initial)**:*** _____

Fecha de nacimiento del menor *(Child's Birth Date)*: _____

Nombre y Apellido del padre, madre, tutor (*Parent/Guardian First and Last Name)*: _____

Dirección del menor *(Child's Address)*: _____

Ciudad *(City)*: _____ **Código postal** *(Zip Code)***:** _____

Género del menor *(Child's Gender):* ☐ Niño *(Boy)* ☐ Niña *(Girl)* ☐ No binario *(Nonbinary)*

Raza/origen étnico del menor *(Child's Race/ Ethnicity):* ☐ Asiático *(Asian)* ☐ Blanco *(White)* ☐ Hispano/Latino *(Hispanic/ Latino*
☐ Indígena estadounidense *(Native American)* ☐ Multirracial *(Multi-racial)* ☐ Negro/Afroestadounidense *(Black / African American)*
☐Nativo de Hawái/islas del Pacífico *(Native Hawaiian / Pacific Islander)*
☐ Desconocido *(Unknown)* ☐Otro (especifique) *Other (please specify):* _____

Nombre de la escuela *(School Name)*: _____

Nomber del maestro *(Teacher Name)*: _____ **Grado** *(Grade)*: _____

Año en el que el menor empieza el kínder *(Year child starts kindergarten)**:*** _____

Información del hogar dental *(Dental Home Information)*: _____
¿Cuál es el seguro dental de su hijo? *(What is your child's dental insurance?)*
☐ Plan de Salud Dental de San Mateo *(HPSM Dental)* ☐ Plan de Salud de la Fundación Kaiser *(Kaiser Foundation Health Plan*)
☐Otro *(Other)*: _____ ☐Ninguno *(None)*
¿Cuántas veces al año visita su hijo al dentista? *(How many times a year does your child visit the dentist?)*
☐ Una vez *(Once)* ☐ Dos veces *(Twice)* ☐ Mas de dos veces *(More than twice)*
¿Ha visitado su hijo al mismo dentista al menos una vez al año durante los últimos dos años seguidos? *(Has your child visited the **same** dentist at least once a year for the past two years in a row)?* ☐ Sí *(Yes)* ☐ No
Nombre de la clínica dental *(Dental clinic name)*: _____
Ciudad de la clínica dental *(Dental clinic city)*: _____
Nombre del dentista *(Dentist name)*: _____
Número de teléfono del dentista *(Dentist phone number)*: _____

Sección 2: Recopilación de datos de salud bucal (debe ser completada por un profesional dental autorizado de California)

Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional). ***IMPORTANT NOTE FOR DENTAL PROVIDERS:*** *Caries experience is both past treatment (e.g., fillings, crowns)* ***and /or*** *untreated decay at the present time (e.g., untreated cavities). Every child with untreated decay automatically also has caries experience for the purposes of this assessment.*

Fecha de la evaluación *(Assessment date):*_____

Ubicación de evaluación *(Assessment location, e.g. school, dental clinic, community event):*_____

Caries sin tratar (deterioro visible presente) *(Untreated decay: Visible decay, untreated cavities):*
☐ Sí *(Yes- if "Yes," caries experience below is automatically also "Yes")* ☐ No

Experiencia de caries (caries visibles y/o empastes presentes) *(Caries Experience: Untreated decay and/or past treatment, e.g. fillings, crowns):*
☐ Sí *(Yes)* ☐ No

Urgencia del tratamiento *(Treatment Urgency: check* ***only one*** *of the 3 options provided. *If "Urgent care needed" is checked, complete Section 3 below.* ***Do not*** *complete Section 3 if "No obvious problem found" or "Early dental care recommended" is checked).*

- ☐ **1. No se encontró ningún problema obvio** *(No obvious problem found)*
- ☐ **2. Se recomienda atención dental temprana** *(Early dental care recommended. Check all that apply):*
  - ☐ Caries sin dolor ni infección *(Caries without pain or infection)*
  - ☐ Al niño le beneficiaría el uso de selladores *(Child would benefit from sealants)*
  - ☐ Al niño le beneficiaría una evaluación adicional *(Child would benefit from further evaluation)*
- ☐ **3. Atención de urgencia necesaria*** *(*Urgent care needed. Check all that apply. Then complete as much of Section 3 below as possible.)*
  - ☐ Dolor *(Pain)*
  - ☐ Infección *(Infection)*
  - ☐ Hinchazón *(Swelling)*
  - ☐ Lesiones en el tejido suave *(Soft tissue lesions)*

Sección 3: Seguimiento a Atención de Urgencia- Solo para los niños con "Atención de urgencia necesaria" marcado en "Urgencia del tratamiento" arriba.** *(*Section 3: Follow up* ***only *for children with "Urgent care needed" marked under "Treatment Urgency" above. Dental provider fills out as much as known and signs. School staff/ other individual responsible for additional follow-up fills out rest of Section 3).*

Se notificó a los padres que el menor tiene necesidades urgentes de atención dental el (fecha):_____
(Parent/caregiver notified child has urgent dental care needs on (date))

Se programó una cita de seguimiento para este menor para el (fecha): _____
(Follow-up appointment for child with urgent dental care needs scheduled for (date))

El menor recibió el tratamiento necesario: *(Child with urgent dental care needs received needed treatment. Check* ***only one*** *of the options below. *If "No" or "I Don't Know," the individual responsible for follow-up is encouraged to contact the parent/caregiver to assist in getting the child to care, and to confirm the child received needed treatment):**

- ☐ Sí *(Yes)*
- ☐ No*
- ☐ No lo sé* *(I Don't Know)*

Firma de profesional dental autorizado *Licensed dental professional signature*	***Número de licencia de CA*** *CA License Number*	***Fecha*** *Date*

La ley establece que las escuelas deben mantener la privacidad de la información de salud de los estudiantes. Gracias a esta ley, el nombre de su hijo no formará parte de ningún informe. Esta información solo se puede usar para fines relacionados con la salud de su hijo. Si tiene alguna pregunta, llame a la escuela. Devuelva este formulario a la escuela *antes del* fin del primer año escolar de su hijo. ***El original de este formulario se guardará en el registro escolar del menor.***

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 form to the school *no later* than by the end of your child's first school year. *Original to be kept in child's school record.***