

Kindergarten Oral Health Assessment (KOHA) Notification Letter

Dear Parent or Guardian:

Having a healthy mouth helps your child do well in school. To make sure your child is ready for school, California law *Education Code* Section 49452.8 requires **every kindergartner in public school and only those first graders who were not in public school the prior year** to have an **oral health assessment/ screening** or dental check-up turned into their school **at the beginning of the school year**. **Transitional kindergartners (TK)** can also complete the assessment.

The Kindergarten Oral Health Assessment Form (attached to this letter) needs to be completed by a licensed dentist or other licensed or registered dental health professional. If your kindergartner or first grader enrolling in public school for their first year **has not** had the form completed by a dentist in the past 12 months, please go to their dentist to get it completed, and return it to your child's school.

If you cannot take your child to a dentist to get the oral health assessment/ screening, or if your child cannot attend an oral health screening event hosted at your school, please visit our webpage here for help in finding a dentist: <https://www.smchealth.org/accessing-oral-health-care>. Or, you may complete the separate **Waiver of Kindergarten Oral Health Assessment Requirement form (attached to this letter)**, and return it to your child's school. You can get copies of all these forms from your child's school.

Your child's identity will not be in any report. Schools keep students' health information private.

If your child does not have health or dental insurance:

Contact San Mateo County's **Health Coverage Unit** by calling toll free:
1-800-223-8383.

Local number: **650-616-2002**.

Email: info-hcu@mscgov.org.

Visit the website: <http://www.smchealth.org/health-insurance>.



To find a dental provider accepting Health Plan of San Mateo Dental (HPSM Dental):

Call the **Health Plan of San Mateo's Dental Line**: 650-616-1522

Email: Dental@hpsm.org.

Visit HPSM Dental's webpage: <https://www.hpsm.org/member/hpsm-dental>



To find a dental provider accepting Kaiser Foundation Health Plan:

Call the Medi-Cal Dental Customer Service Center: 1-800-322-6384 (TTY 1-800-735-2922).

Visit the Medi-Cal Dental (Smile, California) webpage: <https://smilecalifornia.org/find-a-dentist/>

For additional oral health information and resources:

Visit the Oral Public Health Program website: <http://www.smchealth.org/oral-health>.

We want your child to be healthy and ready for school! Here is important advice to help your child stay healthy:

- Baby teeth are very important, even though they fall out. Children need healthy baby teeth to eat, talk, smile, and feel good about themselves. Children with cavities may have pain, difficulty eating, stop smiling, and have problems paying attention and learning at school.
- Take your child to the dentist **every six months, starting when their first baby tooth comes in**. Dental check-ups can help keep your child's mouth healthy and free of pain, and are covered by dental insurance plans.
- Choose healthy foods and drinks for the entire family, like fresh fruits and vegetables, water and milk.
- Help your child brush their teeth at least 2 times a day with toothpaste that contains fluoride for 2 minutes, and floss daily.
- Limit candy and sweet drinks like punch, juice or soda. Sweet drinks and candy contain a lot of sugar, which causes cavities and leaves less room for your child to have healthy foods and drinks. Sweet drinks and candy can also cause weight problems, which may lead to other diseases, such as diabetes
- **Fluoride** is an important mineral that your child needs because it makes their teeth stronger and protects them from cavities. It is found in safe amounts in our drinking water and in toothpaste. Your dentist may recommend your child also receive **fluoride treatments, like "fluoride varnish."** Fluoride varnish is painless and painted on their teeth. If your family drinks mostly bottled water, your child may not be getting enough fluoride from water to protect their teeth. **Fluoride treatments are free services covered by HPSM Dental every 6 months, or more frequently if your child has a higher risk of tooth decay.**
- **"Sealants"** are painless, clear coatings ("seals") put on your child's permanent back teeth (molars). They are recommended for all children because they protect teeth from harmful bacteria and cavities, and they last for several years. **Sealants are covered by insurance for kids.**

If you have questions about the oral health assessment requirement, please contact your child's school.

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.

Waiver of Kindergarten Oral Health Assessment (KOHA) Requirement

Please fill out this form if you need to excuse your child from the kindergarten 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: <small>MM - DD - YYYY</small> |
| Address: | | | Apt.: |
| City: | | Zip code: | |
| School Name: | Teacher: | Grade: | Year child starts kindergarten: <small>YYYY</small> |
| Parent/Guardian First Name: | Parent/Guardian Last Name: | Child's Gender: <input type="checkbox"/> Boy <input type="checkbox"/> Girl <input type="checkbox"/> Nonbinary | |
| Child's Race/Ethnicity: <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Multi-racial <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other (please specify): | | | |

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):

| | |
|--------------------------|--|
| <input type="checkbox"/> | I cannot find a dental office that will take my child's dental insurance plan. My child's dental insurance plan is: <input type="checkbox"/> Health Plan of San Mateo Dental <input type="checkbox"/> Kaiser Foundation Health Plan (Kaiser) <input type="checkbox"/> None <input type="checkbox"/> Other: |
| <input type="checkbox"/> | I cannot afford an assessment for my child. |
| <input type="checkbox"/> | 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). |
| <input type="checkbox"/> | I cannot get to a dentist easily (e.g., do not have transportation, located too far away). |
| <input type="checkbox"/> | I do not believe my child would benefit from an assessment. |
| <input type="checkbox"/> | 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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Original to be kept in child's school record.