**Part 3 — Oral Health Assessment/Screening**

HAR-3 REV. 7/2018

**Health Care Provider must complete and sign the oral health assessment.**

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

|  |  |  |
| --- | --- | --- |
| Student Name (Last, First, Middle) | Birth Date | Date of Exam |
| School | Grade | * Male ❑ Female |

Home Address

|  |  |  |
| --- | --- | --- |
| Parent/Guardian Name (Last, First, Middle) | Home Phone | Cell Phone |

|  |  |  |  |
| --- | --- | --- | --- |
| **Dental Examination** | **Visual Screening** | **Normal** | **Referral Made:** |
| Completed by: | Completed by: | * Yes | * Yes |
| * Dentist | * MD/DO | * Abnormal (Describe) | * No |
|  | * APRN |  |  |
|  | * PA * Dental Hygienist |  |  |
| **Risk Assessment** | **Describe Risk Factors** | | |
| * Low | * Dental or orthodontic appliance | | * Carious lesions |
| * Moderate | * Saliva | | * Restorations |
| * High | * Gingival condition | | * Pain |
|  | * Visible plaque | | * Swelling |
|  | * Tooth demineralization | | * Trauma |
|  | * Other | | * Other |

Recommendation(s) by health care provider:

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential

use in meeting my child’s health and educational needs in school.

Signature of Parent/Guardian Date

Signature of health care provider DMD / DDS / MD / DO / APRN / PA / RDH Date Signed Printed/Stamped ***Provider*** Name and Phone Number