

Kentucky law, KRS 156.160(i), requires proof of a dental screening or examination by a dentist, dental hygienist, physician, registered nurse, advanced registered nurse practitioner, or physician assistant. This evidence shall be presented to the school no later than January 1 of the first year that a five (5) or six (6) year old is enrolled in public school.

<p><b>Student Name:</b> _____  <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Last</span> <span>First</span> <span>Middle</span> </div> </p> <p>Birth date: ____ / ____ / ____      Gender:    <input type="checkbox"/> 0 Male    <input type="checkbox"/> 1 Female</p> <p>Parent or Guardian: _____  <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Name</span> <span>Relationship</span> </div> </p> <p>Address: _____      City: _____</p> <p>Phone Number: _____      School: _____</p> <p style="text-align: center;">Date of Exam/Screening ____ / ____ / ____</p>		<p>Test Type (check one)</p> <p><input type="checkbox"/> Screening</p> <p><input type="checkbox"/> Exam</p> <hr/> <p><b>Screener's Name:</b> _____</p> <p>Screener's Address: _____</p> <p>Phone Number: _____ Screening Date: _____</p> <p>Screener's Signature: _____</p> <p><b>Professional affiliation:</b> (Please check one)</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> Dentist</div> <div style="width: 50%;"><input type="checkbox"/> Dental Hygienist</div> <div style="width: 50%;"><input type="checkbox"/> Physician Assistant</div> <div style="width: 50%;"><input type="checkbox"/> LHD Registered Nurse with KIDS Smiles training</div> <div style="width: 50%;"><input type="checkbox"/> APRN</div> <div style="width: 50%;"><input type="checkbox"/> Physician</div> </div>
<p><b>Untreated Decay:</b> (Check one)</p> <p><input type="checkbox"/> 0 No untreated cavities</p> <p><input type="checkbox"/> 1 Untreated cavities</p>	<p><b>Treated Decay:</b> (Check one)</p> <p><input type="checkbox"/> 0 No treated cavities</p> <p><input type="checkbox"/> 1 Treated cavities</p>	
<p><b>Pattern of Early Childhood Cavities:</b> (Check one)</p> <p><input type="checkbox"/> 0 No Early Childhood Cavities</p> <p><input type="checkbox"/> 1 Early Childhood Cavities Present</p>	<p><b>Treatment Urgency:</b> (Check one)</p> <p><input type="checkbox"/> 0 No obvious problem</p> <p><input type="checkbox"/> 1 Early dental care needed</p> <p><input type="checkbox"/> 2 Referral for Urgent Care  <small>NOTE: Comment required if marked.</small></p>	<p><b>Comments:</b></p>