Washtenaw I S D
A REGIONAL EDUCATIONAL SERVICE AGENCY

Washtenaw ISD Preschool Programs
Oral Health Form

Dear Parent, please provide this form to your child's Dentist to be completed. Per program requirements, a dental exam should be completed every 6 months and provided to the Preschool within 90 days of the first day of school.

This practice is the child's dental home: ☐ Yes ☐ No

Patient Information

Child's name	Date of birth	Date of examination

Current Oral Health Status

Does the child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)
Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No
Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination:	☐ Yes	☐ No
X-rays:	☐ Yes	☐ No
Cleaning:	☐ Yes	☐ No
Fluoride varnish:	☐ Yes	☐ No
Dental sealants:	☐ Yes	☐ No

Caries Risk Assessment

☐ High ☐ Medium ☐ Low

Referral to Specialty Care

☐ Yes ☐ No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings:	☐ Yes	☐ No
Crowns:	☐ Yes	☐ No
Extractions:	☐ Yes	☐ No
Emergency care:	☐ Yes	☐ No

Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: Yes No Next recall date: _____/_____/_____
More appointments needed for treatments? Yes No

If yes: Approximate number of appointments needed: _____

Next appointment: Date: _____ Time: _____

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider Name *(please print)*	Phone number	Fax number

Practice name	Address

Provider signature	Date of signature

Great Start Readiness Program
Michigan's Nationally Recognized Pre-K Program

Reset Form

Date program received: _____