

## Dental Screening Form

When the Health Assessment Transmittal Form issued by NCDPI is used to complete the NC Pre-K child's health assessment, a **separate dental screening** must also be completed due to it not being included on the NCDPI form. Per NC Child Care Rule 10A NCAC 09 .3005 Child Health Assessment, the child's health assessment must include a dental screening, which may be recorded on this form.

<b>Child's Name:</b> _____ <b>Birth date:</b> ____/____/____ <b>Gender:</b> ____ Male ____ Female <b>Parent or Guardian:</b> _____ <b>Address:</b> _____ <b>City:</b> _____ <b>Phone number:</b> _____ <b>School/Pre-K:</b> _____
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Screener's Name \_\_\_\_\_ Screening Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Organization/Practice Name \_\_\_\_\_

Phone number \_\_\_\_\_

**Professional affiliation (please check one):**

- \_\_\_\_ Dentist
- \_\_\_\_ Dental Hygienist
- \_\_\_\_ Physician
- \_\_\_\_ Physician Assistant
- \_\_\_\_ Registered Nurse
- \_\_\_\_ Other Health Professional: \_\_\_\_\_

**Pattern of early childhood cavities:**

- ☐ No cavities/decay present or no obvious problem
- ☐ Cavities/decay present or dental care needed (comment required)
- ☐ Referral for Urgent Care (comment required)

<b>Comments:</b>
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**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_



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## NORTH CAROLINA HEALTH ASSESSMENT TRANSMITTAL FORM

This form and the information on this form will be maintained on file in the school attended by the student named herein and is confidential and not a public record.

(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

### PARENT to COMPLETE THIS SECTION

**Student Name:**

(Last)

(First)

(Middle)

☐ M ☐ F

**Birthdate (M/D/YYYY):**

**School Name:**

**Hispanic of Latino Origin:** ☐ 1 Yes ☐ 2 No

**Race:**

☐ 1 Other Non-White ☐ 2 White ☐ 3 Black ☐ 4 American Indian ☐ 5 Chinese  
☐ 6 Japanese ☐ 7 Hawaiian ☐ 8 Filipino ☐ 9 Other Asian ☐ 10 Unknown

**Home Address:**

**City:**

**State:**

**County:**

**Parent Information: Name of Parent, Guardian, or person standing in loco parentis:**

**Telephone(s)**

Home:

Work:

Cell Phone:

**Health Concerns to be shared with authorized persons (school administrators, teachers, and other school personnel who require such information to perform their assigned duties):**

### HEALTH CARE PROVIDER TO COMPLETE THIS SECTION

**Medications prescribed for student:**

**Student's allergies, type, and response required:**

**Special diet instructions:**

**Health-related recommendations to enhance the student's school performance:**

**Vision screening information:**

Passed vision screening: ☐ Yes ☐ No

Concerns related to student's vision:





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**Hearing screening information:**

Passed hearing screening: ☐ Yes ☐ No

Concerns related to student's hearing:

**Recommendations, concerns, or needs related to student's health and required school follow-up:**

**School follow-up needed:** ☐ Yes ☐ No

**Medical Provider Comments:**

**Please attach other applicable school health forms:**

Immunization record attached: ☐  
School medication authorization form attached: ☐  
Diabetes care plan attached: ☐  
Asthma action plan attached: ☐  
Health care plans for other conditions attached: ☐

**Health Care Professional's Certification**

I certify that I performed, on the student named above, a health assessment in accordance with G.S. 130A-440(b) that included a medical history and physical examination with screening for vision and hearing, and if appropriate, testing for anemia and tuberculosis. I certify that the information on this form is accurate and complete to the best of my knowledge.

Name:

Title:

Signature: \_\_\_\_\_

Date (m/d/yyyy):

Practice/Clinic Name:

Practice/Clinic Address:

Practice/Clinic City:

State:

Zip:

Phone:

Fax:

Provider Stamp Here:

