

## McCabe Union Elementary School District Oral Health Assessment/Waiver Request Form

California law, *Education Code* Section 49452.8, now requires that your child have an oral health assessment by May 31 in kindergarten or first grade, whichever is his or her first year of public school. The law specifies that the assessment must be performed by a licensed dentist or other licensed or registered dental health professional. Oral health assessments that have happened within the 12 months before your child enters school also meet this requirement. If you cannot take your child for this assessment, you may be excused from this requirement by filling out Section 3 of this form.

### Section 1

#### To be completed by the parent or guardian

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name:	Child's race/ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Unknown		

### Section 2

#### Oral Health Data Collection

#### To be completed by the dental professional conducting the assessment

Assessment Date:	<u>Visible caries and/or fillings present:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Visible caries present:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Treatment Urgency:</u> <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended <input type="checkbox"/> Urgent care needed
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*Dental professional's signature*

*Date*

**Return this form to the school by May 31**

*Original to be retained in child's school record.*

Child's First Name: _____	Last Name: _____	Middle Initial: _____
Child's Birth Date: _____	School: _____	Teacher: _____

**Section 3**  
**Waiver of Oral Health Assessment Requirement**  
**To be completed by a parent or guardian requesting to be excused from this requirement**

I request that my child be excused from the oral health assessment requirement for the following reason: (Please check the box that best describes the reason.)

- I am unable to find a dental office that will take my child's insurance plan.  
My child is covered by the following insurance plan:
- Medi-Cal/Denti-Cal     Healthy Families     Healthy Kids     None
  - Other \_\_\_\_\_

- I cannot afford an oral health assessment for my child.
- I do not wish my child to receive an oral health assessment.

Optional: other reasons my child could not get an oral health assessment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

California law requires schools to maintain the privacy of students' health information. Your child's identity will not be associated with any report produced as a result of this requirement. If you have any questions about this requirement, please contact your school office.

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***Signature of parent or guardian***

***Date***

**Return this form to the school by May 31, 20\_\_\_\_**

*Original to be retained in child's school record.*