Kindergarten Oral Health Assessment (KOHA) Notification Letter

Dear Parent or Guardian:

Having a healthy mouth helps your child do well in school. To make sure your child is ready for school, California law Education Code Section 49452.8 requires all **public school students in either Transitional Kindergarten (TK) or Kindergarten** to have an oral health screening, called the Kindergarten Oral Health Assessment (KOHA)**.** The required KOHA form is attached to this letter. It must be completed by a licensed dentist or dental professional. *If your child is in first grade and did not attend public school in TK or Kindergarten, they also need to complete the assessment.*

The KOHA only needs to be completed once. It should be turned into your child's school as early as possible in the school year. It can be completed at your child's dental office. Or, many schools in San Mateo County offer the KOHA screening free at the school. Your child's school will notify you if the KOHA will be offered at the school.

If you cannot take your child to a dentist, or they missed the free KOHA screening if offered at their school, please visit our webpage here for help in finding a dentist: https://www.smchealth.org/accessing-oral-health-care.

Or, you may complete the separate **Waiver of Kindergarten Oral Health Assessment Requirement form (attached to this letter),** and return it to your child's school. You can get copies of all these forms from your child's school.

Your child's identity will not be in any report. Schools keep students' health information private.

If your child does not have health or dental insurance:

Contact San Mateo County's **Health Coverage Unit** by calling toll free: **1-800-223-8383**.
Local number: **650-616-2002**.
Email: info-hcu@mscgov.org.
Visit the website: http://www.smchealth.org/health-insurance.

To find a dental provider accepting Health Plan of San Mateo Dental (HPSM Dental):

Call the **Health Plan of San Mateo's Dental Line**: 650-616-1522
Email: Dental@hpsm.org.
Visit HPSM Dental's webpage: https://www.hpsm.org/member/hpsm-dental

To find a dental provider accepting Kaiser Foundation Health Plan:

Call the Medi-Cal Dental Customer Service Center: 1-800-322-6384 (TTY 1-800-735-2922).
Visit the Medi-Cal Dental (Smile, California) webpage: https://smilecalifornia.org/find-a-dentist/

For additional oral health information and resources:

Visit the Oral Public Health Program website: http://www.smchealth.org/oral-health.

We want your child to be healthy and ready for school! Here is important advice to help your child stay healthy:

- Baby teeth are very important, even though they fall out. Children need healthy baby teeth to eat, talk, smile, and feel good about themselves. Children with cavities may have pain, difficulty eating, stop smiling, and have problems paying attention and learning at school.

- Take your child to the dentist **every six months**, **starting when their first baby tooth comes in**. Dental check-ups can help keep your child's mouth healthy and free of pain, and are covered by dental insurance plans.

- Choose healthy foods and drinks for the entire family, like fresh fruits and vegetables, water and milk.

- Help your child brush their teeth at least 2 times a day with toothpaste that contains fluoride for 2 minutes, and floss daily.

- Limit candy and sweet drinks like punch, juice or soda. Sweet drinks and candy contain a lot of sugar, which causes cavities and leaves less room for your child to have healthy foods and drinks. Sweet drinks and candy can also cause weight problems, which may lead to other diseases, such as diabetes

- **Fluoride** is an important mineral that your child needs because it makes their teeth stronger and protects them from cavities. It is found in safe amounts in our drinking water and in toothpaste. Your dentist may recommend your child also receive **fluoride treatments, like "fluoride varnish."** Fluoride varnish is painless and painted on their teeth. If your family drinks mostly bottled water, your child may not be getting enough fluoride from water to protect their teeth. **Fluoride treatments are free services covered by HPSM Dental every 6 months, or more frequently if your child has a higher risk of tooth decay.**

- **"Sealants"** are painless, clear coatings ("seals") put on your child's permanent back teeth (molars). They are recommended for all children because they protect teeth from harmful bacteria and cavities, and they last for several years. **Sealants are covered by insurance for kids.**

If you have questions about the oral health assessment requirement, please contact your child's school.

Kindergarten Oral Health Assessment (KOHA) Form: San Mateo County

California law (*Education Code* Section 49452.8) says every child enrolled in kindergarten in a public school, and any child enrolled in first grade *who did not attend public school the previous year*, must have a dental check-up (assessment). Transitional kindergartners can also complete the assessment. It should be turned in at the beginning of the school year. A California licensed dental professional must do the check-up and fill out **Sections 2 and 3** of this form. If your child had a dental check-up in the last 12 months, ask your dentist to fill out Sections 2 and 3. To find a dental provider in San Mateo County, visit: www.smchealth.org/accessing-oral-health-care. If you are unable to get a dental check-up for your child, fill out the separate Waiver of Oral Health Assessment Requirement Form.

This assessment will let you know if there are any dental problems that need attention by a dentist. This assessment will also be used to evaluate our oral health programs. Children need good oral health to speak with confidence, express themselves, be healthy, and ready to learn. Poor oral health has been related to lower school performance, and poorer social relationships. Thank you for supporting the health and well-being of California's children.

Section 1: Child's Information (Filled out by parent or guardian)

Child's First and Last Name: _____ **Middle Initial:** _____

Child's Birth Date: _____

Address (include Apt. if applicable): _____

City: _____ **Zip Code:** _____

School Name: _____

Teacher Name: _____ **Grade:** _____

Year child starts kindergarten: _____

Parent/Guardian First and Last Name: _____

Child's Gender: ☐ Boy ☐ Girl ☐ Nonbinary

Child's Race/ Ethnicity: ☐ Asian ☐ Black / African American ☐ Hispanic/ Latino ☐ Multi-racial
☐ Native American ☐ Native Hawaiian/ Pacific Islander ☐ White ☐ Unknown
☐ Other (please specify): _____

Dental Home Information:

What is your child's dental insurance?

☐ Health Plan of San Mateo Dental (HPSM Dental) ☐ Kaiser Foundation Health Plan (Kaiser)
☐ Other: _____
☐ None

How many times a year does your child visit the dentist? ☐ Once ☐ Twice ☐ More than twice

Has your child visited the **same** dentist at least once a year for the past two years in a row? ☐ Yes ☐ No

Dental clinic name: _____ Dental clinic city: _____

Dentist name: _____ Dentist phone number: _____

Student name:_____ **Grade:**_____

Section 2: Oral Health Screening Assessment

Filled out by a California licensed dental professional. IMPORTANT NOTE FOR DENTAL PROVIDER: *Caries experience is both past treatment (e.g., fillings, crowns)* ***and /or*** *untreated decay at the present time (e.g., untreated cavities). Every child with untreated decay automatically also has caries experience for the purposes of this assessment.*

Assessment date:_____
Assessment Location: *(e.g. school, dental clinic, community event)**:***_____

Untreated decay *(Visible decay, untreated cavities):*

☐ Yes *(If "Yes," caries experience below is automatically also "Yes")* ☐ No

Caries Experience *(Untreated decay and/or past treatment, e.g. fillings, crowns):*

☐ Yes ☐ No

Treatment Urgency *(check **only one** of the 3 options provided below).*
If "Urgent care needed" is checked, complete Section 3 below. **Do not** complete Section 3 if "No obvious problem found" or "Early dental care recommended" is checked.

- ☐ **1. No obvious problem found**
- ☐ **2. Early dental care recommended** *(Check all that apply).*
  - ☐ Caries without pain or infection
  - ☐ Child would benefit from sealants
  - ☐ Child would benefit from further evaluation
- ☐ **3. Urgent care needed*** *(Check all that apply. Then complete as much of Section 3 below as possible).*
  - ☐ Pain
  - ☐ Infection
  - ☐ Swelling
  - ☐ Soft tissue lesions

***Section 3: Follow up *only for children with "Urgent care needed"* marked under "Treatment Urgency" above.** *(Dental provider fills out as much as known and signs. School staff/ other individual responsible for additional follow-up fills out rest of Section 3).*

Parent/caregiver notified child has urgent dental care needs on (date): _____

Follow-up appointment for child with urgent dental care needs scheduled for (date):_____

Child with urgent dental care needs received needed treatment *(Check **only one** of the options below).*
If "No" or "I Don't Know," the individual responsible for follow-up is encouraged to contact the parent/caregiver to assist in getting the child to care, and to confirm the child received needed treatment.*

- ☐ Yes
- ☐ No*
- ☐ I Don't Know*

_____ _____ _____
Licensed dental professional signature ***CA License Number*** ***Date***

The law states schools must keep student health information private. Your child's name will not be part of any report as a result of this law. This information may only be used for purposes related to your child's health. If you have questions, please call your school. **Return form to the school *no later* than by the end of your child's first school year. *Original to be kept in child's school record.***

California Department of Public Health
San Mateo County Health, Revised 2024

Waiver of Kindergarten Oral Health Assessment (KOHA) Requirement

Please fill out this form if you need to excuse your child from the kindergarten oral health assessment requirement. Sign and return this form to the school where it will be kept confidential.

Section 1: Child's Information (Filled out by parent or guardian)

Child's First Name:	Last Name:	Middle Initial:	Child's Birth Date: MM – DD – YYYY
Address: City: Zip code:			Apt.:
School Name:	Teacher:	Grade:	Year child starts kindergarten: YYYY
Parent/Guardian First Name:	Parent/Guardian Last Name:	Child's Gender: ☐ Boy ☐ Girl ☐ Nonbinary	
Child's Race/Ethnicity: ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Multi-racial ☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Unknown ☐ Other (please specify):			

Section 2: To be filled out by parent or guardian ONLY IF asking to be excused from this requirement

Please excuse my child from the assessment because (check the box that best describes the reason):

☐	I cannot find a dental office that will take my child's dental insurance plan. My child's dental insurance plan is: ☐ Health Plan of San Mateo Dental ☐ Kaiser Foundation Health Plan (Kaiser) ☐ None ☐ Other:
☐	I cannot afford an assessment for my child.
☐	I cannot find the time to get to a dentist (e.g., cannot get the time off from work, the dentist does not have convenient office hours).
☐	I cannot get to a dentist easily (e.g., do not have transportation, located too far away).
☐	I do not believe my child would benefit from an assessment.
☐	Other (please specify the reason not listed above for why you are seeking a waiver of this assessment for your child):

If asking to be excused from this requirement:

• _____ MM – DD – YYYY

Signature of parent or guardian ***Date***

The law states schools must keep student health information private. Your child's name will not be part of any report as a result of this law. This information may only be used for purposes related to your child's health. If you have questions, please call your school. **Return this form to the school *no later than* by the end of your child's first school year.**

Original to be kept in child's school record.