

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.**