

**Charlayne Sprague**

Superintendent

**Douglas M. Claflin**

Assistant Superintendent of Business Services

**Laura Rowland**

Assistant Superintendent of Personnel Services

**Jeannie Tavalazzi**

Assistant Superintendent of Instruction and Pupil Services

**Elizabeth Freer**

Executive Director of Special Education



6061 East Avenue, Etiwanda, California 91739

[www.etiwanda.k12.ca.us](http://www.etiwanda.k12.ca.us)

(909) 899-8286

FAX (909) 899-8386

**Board of Trustees**

Robert Garcia

Matthew Gordon

Dr. Fermín Jaramillo

Dayna Karsch

April McAllaster

## STATE REQUIRED ORAL HEALTH ASSESSMENT

Dear Parent or Guardian:

To ensure your child is ready for school, California law, *Education Code* Section 49452.8, requires that your child have an oral health assessment or dental check-up by May 31 of their first year in public school (TK, Kindergarten or first grade). Assessments completed within 12 months before your child enters school also meet this requirement.

Every child needs an oral health assessment completed on the oral health assessment form from a licensed dentist or other licensed or registered dental health professional to meet this requirement. If your child has not had an oral health assessment in the past 12 months, one will be needed before May 31<sup>st</sup>. The form is included with this letter and linked here: [Oral Health Assessment Form](#).

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.

The following resources will help you find a dentist to complete this requirement for your child:

1. You can call the Medi-Cal Telephone Service Center at 1-800-322-6384 or visit Smile California - Find a Dentist (<https://smilecalifornia.org/find-a-dentist/>) to find a dentist that accepts Medi-Cal. For help enrolling your child in Medi-Cal, you can apply by mail, go in person to your local Social Services office, or online at Apply for Medi-Cal. (<https://www.dhcs.ca.gov/services/medi-cal/pages/applyformedi-cal.aspx>)
2. For additional resources that may be helpful, contact your local public health department, select "Apply for Health Coverage" (<https://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx>). Information on agencies that serve your area can be obtained by calling (909) 388-0245.
3. If your child does not qualify for Medi-Cal, you may contact your school health office for additional information regarding other available assistance.

If you will not or cannot take your child for this required assessment, please complete, sign and date the attached waiver form and return it to your child's school or to [healthservices@etiwanda.org](mailto:healthservices@etiwanda.org). Additional copies of the Oral Health Assessment Waiver Form are available from your child's school, on Etiwanda's website [[Oral Health Assessment Waiver Form](#)] or online at [Oral Health Assessment Waiver Form](#)

Remember, your child is not healthy and ready for school if your child has poor dental health! Below is important advice to help your child stay healthy:

- Take your child to the dentist twice a year.
- Choose healthy foods for the entire family. Fresh foods are usually the healthiest foods.
- Brush teeth at least twice a day with toothpaste that contains fluoride.
- Limit candy and sweet drinks, such as punch or soda. Sweet drinks and candy contain a lot of sugar which causes cavities and replaces important nutrients in your child's diet. Sweet drinks and candy also contribute to weight problems which may lead to other diseases, such as diabetes. The less candy and sweet drinks, the better!

Baby teeth are very important. They are not just teeth that will fall out. Children need their teeth to eat properly, talk, smile, and feel good about themselves. Children with cavities may have difficulty eating, stop smiling, and have problems paying attention and learning at school. Tooth decay is an infection that does not heal and can be painful if left without treatment. If cavities are not treated, children can become sick enough to require emergency room treatment, and their adult teeth may be permanently damaged.

Many things influence a child's progress and success in school, including health. Children must be healthy to learn and children with cavities are not healthy. Cavities are preventable, but they affect more children than any other chronic disease.

If you have any questions, please contact your child's school.

Sincerely,

*Rebecca Pierce, RN, BSN, PHN*

Rebecca Pierce, Health Services Coordinator

### Oral Health Assessment Form

California law (*Education Code* Section 49452.8) says every child must have a dental check-up (assessment) by May 31<sup>st</sup> of his/her first year in public school. A California licensed dental professional must do the check-up and fill out Section 2 of this form. If your child had a dental check-up in the last 12 months, ask your dentist to fill out Section 2. 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, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of California's children.

#### 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:			Apt.:										
City:		ZIP Code: 											
School Name:	Teacher:	Grade:	Year child starts kindergarten:   Y   Y   Y   Y										
Parent/Guardian First Name:	Parent/Guardian Last Name:		Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female										
Child's Race/Ethnicity:	<table><tr><td><input type="checkbox"/> White</td><td><input type="checkbox"/> Native American</td></tr><tr><td><input type="checkbox"/> Black/African American</td><td><input type="checkbox"/> Multi-racial</td></tr><tr><td><input type="checkbox"/> Hispanic/Latino</td><td><input type="checkbox"/> Native Hawaiian/Pacific Islander</td></tr><tr><td><input type="checkbox"/> Asian</td><td><input type="checkbox"/> Unknown</td></tr><tr><td><input type="checkbox"/> Other (please specify)</td><td></td></tr></table>			<input type="checkbox"/> White	<input type="checkbox"/> Native American	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Multi-racial	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Asian	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other (please specify)	
<input type="checkbox"/> White	<input type="checkbox"/> Native American												
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Multi-racial												
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Native Hawaiian/Pacific Islander												
<input type="checkbox"/> Asian	<input type="checkbox"/> Unknown												
<input type="checkbox"/> Other (please specify)													

*Continued on Next Page*

## Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional)

**IMPORTANT NOTE:** Consider each box separately. Mark each box.

Assessment Date:  MM – DD – YYYY	Untreated Decay (Visible Decay Present)  <input type="checkbox"/> Yes <input type="checkbox"/> No	*Caries Experience (Visible decay and/or fillings present)  <input type="checkbox"/> Yes <input type="checkbox"/> No
Treatment Urgency: <div> <input type="checkbox"/> <b>No obvious problem found</b> <input type="checkbox"/> <b>Early dental care recommended</b>            (caries without pain or infection; or child would benefit from sealants or further evaluation)         </div> <div> <input type="checkbox"/> <b>Urgent care needed</b> (pain, infection, swelling or soft tissue lesions)         </div>		
<div> <div> <div></div> <div> <i><b>Licensed Dental Professional Signature</b></i> </div> </div> <div> <div></div> <div> <i><b>CA License Number</b></i> </div> </div> <div> <div>MM – DD – YYYY</div> <div> <i><b>Date</b></i> </div> </div> </div>		

\*Check "Yes" for Caries experience if there is presence of untreated decay or fillings  
Check "No" for Caries experience if there is no untreated decay and no fillings

## Section 3: Follow-up to Urgent Care (Filled out by entity responsible for follow up)

Parent notified that child has urgent dental care need on:	MM – DD – YYYY
A follow-up appointment for this child has been scheduled for:	MM – DD – YYYY
Did child receive needed treatment?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> (If no, entity responsible for follow-up will be encouraged to check back in with parent) <input type="checkbox"/> <b>I don't know</b>

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* May 31st of your child's first school year.**

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

### Waiver of Oral Health Assessment Requirement

Please fill out this form if you need to excuse your child the 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:			Apt.:										
City:		ZIP code: 											
School Name:	Teacher:	Grade:	Year child starts kindergarten:   Y   Y   Y   Y										
Parent/Guardian First Name:	Parent/Guardian Last Name:		Child's Gender: Male      Female										
Child's Race/Ethnicity:	<table><tr><td><input type="checkbox"/> White</td><td><input type="checkbox"/> Native American</td></tr><tr><td><input type="checkbox"/> Black/African American</td><td><input type="checkbox"/> Multi-racial</td></tr><tr><td><input type="checkbox"/> Hispanic/Latino</td><td><input type="checkbox"/> Native Hawaiian/Pacific Islander</td></tr><tr><td><input type="checkbox"/> Asian</td><td><input type="checkbox"/> Unknown</td></tr><tr><td><input type="checkbox"/> Other (please specify)</td><td></td></tr></table>			<input type="checkbox"/> White	<input type="checkbox"/> Native American	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Multi-racial	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Asian	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other (please specify)	
<input type="checkbox"/> White	<input type="checkbox"/> Native American												
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Multi-racial												
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Native Hawaiian/Pacific Islander												
<input type="checkbox"/> Asian	<input type="checkbox"/> Unknown												
<input type="checkbox"/> Other (please specify)													

*Continued on Next Page*

**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):	
<input type="checkbox"/>	I cannot find a dental office that will take my child's dental insurance plan. My child's dental insurance plan is:  <div><input type="checkbox"/> Medi-Cal                      Covered California                      <input type="checkbox"/> Healthy Kids                      <input type="checkbox"/> None</div> <div><input type="checkbox"/> Other: _____</div>
<input type="checkbox"/>	I cannot afford an assessment for my child.
<input type="checkbox"/>	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).
<input type="checkbox"/>	I cannot get to a dentist easily (e.g., do not have transportation, located too far away).
<input type="checkbox"/>	I do not believe my child would benefit from an assessment.
<input type="checkbox"/>	Other (please specify the reason not listed above for why you are seeking a waiver of this assessment for your child): _____ _____
<b>If asking to be excused from this requirement:</b>  <div><div>► _____</div><div>MM – DD – YYYY</div><div><b>Signature of parent or guardian</b>                      <b>Date</b></div></div>	

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* May 31 of your child's first school year.**

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