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.

Child's Name: _____
Birth date: ____/____/____
Gender: ____ **Male** ____ **Female**
Parent or Guardian: _____
Address: _____
City: _____
Phone number: _____ **School/Pre-K:**_____

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:

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

Comments:

Signature_____ **Date**_____

DCD 0108
12/99

Children's Medical Report

Name of Child_____ Birthdate _____

Name of Parent or Guardian_____

Address of Parent of Guardian _____

A. Medical History (May be completed by parent)

1. Is child allergic to anything? No___ Yes___ If yes, what?_____

2. Is child currently under a doctor's care? No___ Yes___ If yes, for what reason?_____

3. Is the child on any continuous medication? No___ Yes___ If yes, what?_____

4. Any previous hospitalizations or operations? No___ Yes___ If yes, when and for what?_____

5. Any history of significant previous diseases or recurrent illness? No___ Yes___ ; diabetes No___Yes___; convulsions No___ Yes___; heart trouble No___ Yes___; asthma No___ Yes___.
   If others, what/when?_____

6. Does the child have any physical disabilities: No___ Yes___ If yes, please describe:_____

Any mental disabilities? No___ Yes___ If yes, please describe:_____

Signature of Parent or Guardian_____ **Date**_____

B. Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N. C. Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DHHS standards for EPSDT program.
Height _____% Weight _____%

Head_____ Eyes_____ Ears_____ Nose_____ Teeth_____Throat_____
Neck_____ Heart_____Chest_____Abd/GU_____Ext_____
Neurological System_____Skin_____Vision_____Hearing_____
Results of Tuberculin Test, if given: Type_____date_____ Normal__Abnormal_____followup_____

Developmental Evaluation: delayed_____age appropriate_____
If delay, note significance and special care needed;_____
_____

Should activities be limited? No___ Yes___ If yes, explain: _____
Any other recommendations:_____
_____
_____

Date of Examination_____

Signature of authorized examiner/title_____ **Phone #**_____