Dear Parent or Guardian,

Your child received a dental screening at school today to fulfill the requirements for Kansas State Statute 72-6251. A dental screening is a short, 30 second visual assessment that does not require instruments and no x-rays or dental services were provided. A dental screening does not replace an in-office dental examination by a dentist. A licensed dentist or dental hygienist completed the screening. The results of the screening indicate that:

Check all that apply.

_____ Your child has no visible signs of an obvious dental problem; this is only a dental screening, not a comprehensive exam. It is recommended your child sees a dentist twice a year to prevent the development of dental disease.
Additional comments: ____________________________________________________________

_____ If your child has not seen a dentist in the last six months, you should schedule an appointment for preventive care (cleaning or sealants).
Additional comments: ____________________________________________________________

_____ Your child appears to have visible signs of dental problems which should be evaluated by a dentist. Please make an appointment at your earliest convenience so that your child can receive a complete examination. Your dentist will determine if any treatment is needed.
Referral recommendation: ________________________________________________________

_____ Your child appears to have visible signs of an urgent dental need. An immediate visit to a dentist for complete examination is recommended.
Referral recommendation: ________________________________________________________

To search for a dental provider in your area, please visit: Assistance in Obtaining Dental Care | KDHE, KS

The American Dental Association recommends everyone see the dentist twice per year for professional cleanings and oral examination. This screening DOES NOT replace the exam provided by your dentist.

Parent: Take this referral to the dentist if it is recommended above. Return the below section to the school nurse with dentist’s signature when work is completed.

______________________________________________________________________________

Child’s name

D.D.S. Signature __________________________________________ Date of Service ____________

☐ Urgent need addressed ☐ Treatment is ongoing ☐ Treatment is complete

If you or someone in your family needs assistance, please visit the KanCare self-portal to see if you are eligible and/or to apply for benefits. cssp.kees.ks.gov/apspssp/.