MVAC Head Start Oral Health Form
Infant, toddler and preschool

Return to: **MVAC Head Start – Health**
706 N. Victory Dr.
Mankato, MN 56001
Fax: (507) 345-2429
Phone: (507) 345-2468
Email: hsfax@mnvac.org

Child's Name:_____ Date of Birth:_____/____/_____

- Is this practice the child's Dental Home? ☐ Yes ☐ No ☐ Referred by another provider for TX only.

Current Oral Health Status

1. Were teeth identified today with untreated decay? ☐ Yes ☐ No
2. Does this child have teeth that have previously been treated for decay? ☐ Yes ☐ No
3. Were Treatment Needs (restorative or emergency care) identified at today's visit?
   ☐ Yes, urgent ☐ Yes, non-urgent ☐ No treatment needs identified today

Oral Health Care Services Delivered at Visit

In the columns below please check all of the services provided at visit.

Diagnostic/Preventative Services

Examination: ☐ No ☐ Yes
X-rays: ☐ No ☐ Yes
Risk Assessment: ☐ No ☐ Yes
Cleaning: ☐ No ☐ Yes
Fluoride Varnish: ☐ No ☐ Yes
Sealants ☐ No ☐ Yes
Medications: ☐ No ☐ Yes
Counseling/Anticipatory Guidance ☐ No ☐ Yes

Recommendations/Referrals

Referral to Specialty Care? ☐ No ☐ Yes
Referred to: _____
_____
Provider will contact referral source? ☐ No ☐ Yes
Is parent to contact referral source to schedule appointment? ☐ No ☐ Yes

Restorative or Emergency Care

Filling: ☐ No ☐ Yes_____ *How many?*
Crown: ☐ No ☐ Yes_____ *How many?*
Pulpotomy: ☐ No ☐ Yes _____ *How many?*
Extraction: ☐ No ☐ Yes _____ *How many?*
Emergency Care: ☐ No ☐ Yes
Other: _____

Follow-up and Future Oral Health Care Service

Was all Treatment completed today? ☐ No ☐ Yes

- *If no ⇩*

Approximate # of appointments needed: _____

_____
Appointment date(s) and time(s)

Next Recall Date: _____/_____ *(month & year)*
Or
Recall appointment is scheduled for:

Date: _____ Time: _____

Parent or Legal Guardian:

By signing this form, I am authorizing the provider to release current dental health information requested on this form, for the above named child, for whom I am legally responsible for, to MVAC Head Start.
The information from this form is used track the child's oral health status while enrolled in Head Start and for sharing non-identifying information with local, regional and state oral health coalitions for the purpose of improving children's oral health in Minnesota.

_____ _____
Parent/Guardian Signature *Date*

_____
Parent/Guardian Printed Name

Date(s) of Visit(s) _____

_____ _____
Provider signature *Date*

_____
Printed Name

_____
Clinic Name and address

_____