Atencion Padres de Familia
Esta carta es para el dentista de su hijo(a)
Por favor firme en el espacio proporcionado para la firma de los padres "Parent/Guardian Signature." Al firmar ésta carta, usted autoriza al dentista a dar –a Head Start- los resultados del examen de su hijo(a). Por favor lleve ésta carta cuando vaya a la cita del examen para que el dentista complete la información requerida. Le agradecemos mucho su colaboración.

Dear Oral Health Care Professional,

According to **(FEDERAL PERFORMANCE STANDARD: 45 CFR 1304.20(a) (1) (ii) & (A))**

Head Start Federal programs are required, within 90 days of enrollment, to obtain from a health care profession a determination as to whether a child is up-to-date on a schedule of age appropriate preventive and primary heath care. The federal guidelines require that each child has a yearly dental exam and completion of needed treatment.

To comply with performance standard requirements we need providers to complete the attached **Dental Examination/Assessment** or send a copy of the child's most current **Proof of Treatment Statement.** If follow-up treatment is needed, please send those records to our Health Services Office when treatment is completed. Also attached is the parent's authorization for "Request for Release of Medical Information"

Thank you for taking the time to complete the information and returning the form to Head Start in a timely manner. Program guidelines require that we keep the information in a confidential child file. If you have any questions, please do not hesitate to call.

Jenny Diaz
Health Services Specialist

735-1062/fax 737-8492

Request for Release of Medical Information

Child's Name/*Nombre del niño*:_____ **Birthdate**/*Fecha de nacimiento*:_____

I give my permission for Benton Franklin Head Start and _____
(Dentist's/Clinic's Name)

to mutually exchange health information concerning my child.

Parent's/Guardian's Name/*Nombre del padre*:_____

_____

Parent's/Guardian's Signature/*Firma del padre* **Date**/*Fecha*

BENTON FRANKLIN HEAD START

1549 Georgia Ave. S.E. Suite B, Richland, WA 99352 (509) 735-1062

DENTAL EXAMINATION/ASSESSMENT

Child's Name:_____ **Date of Birth:**_____

1. Is the child now receiving: fluoridated water? _____**Yes** _____**No**

fluoride supplements? _____**Yes** _____**No**

2. This child (_____ has / _____ has not) previously seen a dentist.

3. Date of exam:_____

4. Treatment Provided

- ❑ Exam
- ❑ Xray
- ❑ Prophy
- ❑ Restoration
- ❑ Sealants
- ❑ Fluoride
- ❑ Duraflor

5. Treatment Needed

____referred to Pedodontist
____excessive work or immediate attention
____can be done within 3 visits
____routine preventive services
____no treatment at this time

Date of follow up appointment:_____
Date follow up was completed:_____

Mark treatment needed

1 2 3 4 5 6 7 8		9 10 11 12 13 14 15 16
O O O O O O O O	Upper	O O O O O O O O
O O O O O		O O O O O
A B C D E		F G H I J
R----------Lingual----------L		
T S R Q P		O N M L K
O O O O O		O O O O O
O O O O O O O O O	Right	O O O O O O O O
32 31 30 29 28 27 26 25		24 23 22 21 20 19 18 17

I certify that I have completed the services listed above.

_____

Name of Dentist or Clinic

Signature_____**Date**_____