WTS Dental Screening Form

Please use this form in an attempt to complete Dental Screening for Wake ThreeSchool Children. Per NC Child Care Rule 10A NCAC 09 .3005 Child Health Assessment, the child's health assessment must attempt 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: _____ WTS Site-:_____

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:

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

Comments:

Signature_____ **Date_____**