Holly Area Schools
Excellence in Action!

Dear Parent or Guardian,

The State of Michigan passed a law [*Public Health Code Act 368 Section 333.9316*] to ensure that children have an opportunity to receive an oral health assessment (dental screening) before they enter kindergarten.

We do not require that your child have a dental screening in order to attend school, but we strongly encourage it. Tooth decay is the most common chronic illness in children. Dental problems can cause pain and make it difficult for children to eat, speak, and sleep, all of which may prevent them from reaching their full learning potential. Good oral health is important to help children be healthy and ready to learn, and the purpose of this screening is to make sure your child does not have any dental problems that would prevent them from doing well in school.

Take the attached Kindergarten Oral Health Assessment Screening Form to any of these locations to have the screening done:

- Your Dental Office
- Local Health Department
- Health Enrollment Fair in August

Return the completed form to the school.

The screening is free if it is done at the local health department or at a pre-kindergarten enrollment event where the health department does the screenings.

Many things influence a child's progress and success in school, including oral health, and we encourage you to have your child screened.

Sincerely,

Jessica Morantes, District Nurse
248-328-3028

Administration Office

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MICHIGAN KINDERGARTEN
ORAL HEALTH ASSESSMENT PROGRAM

KINDERGARTEN ORAL HEALTH ASSESSMENT FORM

The Kindergarten Oral Health Assessment law [*Public Health Code Act 368 Section 333.9316*] was passed to ensure that children entering their first year of school are able to receive an oral health assessment (dental screening) prior to starting school. Good oral health is important to help children stay healthy and ready to learn. This **optional assessment** will let you know if your child has any dental problems that require attention by a dentist. The assessment must be conducted by a Registered Dental Hygienist, Dentist, or Dental Therapist.

STUDENT INFORMATION	
Child's Name (Last, First, Middle)	Date of Birth (mm/dd/yy)
Address (Number, Street, City, Zip Code)	
Parent/Guardian Name (Last, First, Middle)	Home/Cell Phone Number

DENTAL EXAM OR ASSESSMENT RECOMMENDATIONS (Licensed dental professional must complete this section)

Child's Name	Has received ☐ Dental Exam ☐ Dental Assessment
Findings (check all that apply) ☐ No urgent needs ☐ Treated decay ☐ Untreated decay	Recommendations (check ONE) ☐ Routine care ☐ Referral for urgent needs/restorative care or specialist
Screening Provider (check one) ☐ Dentist ☐ Dental Therapist ☐ Dental Hygienist	
Provider Signature	Provider Name
Phone Number	Date

Additional Comments: _____

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