Children's Basic Oral Health Screening Results Letter

Schools please note: This form is for SAMPLE USE ONLY and requires individual administrative and legal review by school personnel to ensure compliance with all applicable laws, regulations, school policies, and local requirements. IDOH will provide a modifiable version of this form upon receipt of an email confirming school review and approval from a school attorney or administrative leader .

Student Name: _____ **Screening Date:** _____

Dear Parent, or Guardian:

Today, your child received a basic oral health screening at school. No x-rays were taken. Please note that this screening was only a visual screening and not a dental examination conducted by the dentist. This exam does not replace a routine dental visit.

The results of the exam show that:

_____ Your child has no visible dental problems but should continue to visit the dentist every 6 months for regular check-ups.

_____ Your child has a tooth, or teeth, that need to be seen by a dentist. The dentist will determine whether treatment is needed.

_____ Your child has a tooth, or teeth, that need immediate care. Contact a dentist **as soon as possible** for a complete evaluation and best treatment.

If you do not have a family dentist and you need help finding care or insurance, email oralhealth@health.in.gov or visit: www.insurekidsnow.gov/coverage/in/index.html

Signature: _____

Indiana Department of Health

Developed & Designed by McMillen Health