Screening Coordinator:

Name _____

Address _____

City _____ State ____ Zip _____

Phone (406) _____

MONTANA DPHHS

Healthy People. Healthy Communities.

Department of Public Health & Human Services

School Oral Health Screening Form

Please send copies to:

MT DPHHS - Oral Health

Family & Community Health Bureau

1400 E Broadway, Rm. A116

Helena, MT 59620 (406) 444-2660

Screening Date _____ / _____ / _____

School _____ City _____ County _____

Screener Name:

☐ Dentist ☐ Nurse ☐ Dental Hygienist ☐ Other

Did Screener Complete Basic Screening Survey Training? ☐ Yes Mo/Yr _____ / _____ ☐ No

Name / ID Number	Grade	Age	Gender		Race/ Ethnicity	Untreated Cavities		Caries Experience		Sealants on Adult Molars		Treatment Urgency			Identify Problem
			M	F	*	Y	N	Y	N	Y	N	No	Early	Urgent	

***KEY**

Race / Ethnicity

W =White

B =Black/African American

H =Hispanic/Latino

A =Asian

AI =American Indian/Alaska Native

NH =Native Hawaiian/Pacific Islander

MR =Multi-racial

U =Unknown

Untreated Cavities (Caries)

Yes = Decay present (>.5 mm or 1/2 mm & brown)

No = No decay present

Caries Experience

Yes =

-Has decay &/or

-Has filling or crown &/or

-Had baby or adult tooth extracted due to decay

No =

-No decay &/or

-No fillings &/or

-No adult molar extracted due to decay

Sealants

Yes = One or more sealants on permanent molars present

No = No sealant present

Treatment Urgency

No = No Obvious Need

Early = Early Care Needed

Urgent = Urgent Care Needed

Name / ID Number	Grade	Age	Gender		Race/ Ethnicity	Untreated Cavities		Caries Experience		Sealants on Adult Molars		Treatment Urgency			Identify Problem
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