School Entry Dental Examination Requirements
Students Entering Kindergarten

Dear Parent and/or Guardian,

Children with healthy teeth live longer, have more productive lives and higher self-esteem. The oral health of your child is important to ensure their school success, health and happiness. Please work with your Dentist and school to make sure your child has a healthy smile and great life!

New enterers in West Virginia public school at first entry of either Pre-K or Kindergarten and all students progressing to grades 2, 7 and 12 should have on file within 45 days of enrollment/entry or prior to the first day of school attendance a record of an oral health examination. If the student does not have proof of an oral health examination during the grade of requirement, the student may be enrolled into the WVDHHR-Oral Health Program's (OHP) Oral Disease Prevention Project. The Oral Health Prevention Project will provide an oral health assessment from a dental provider regardless of the ability to pay if the parent/guardian provides approval/consent for the student to participate.

The dental examination should:

- Be completed within one year of the date of pre-enrollment or at the time of enrollment. There will be a grace period of 45 days from enrollment (first day of class) for students to provide proof of the completed dental examination.
- Provide proof that the student completed a dental examination within the last 12 months at the time of enrollment. Your school may provide a form to document a student dental examination or the Dentist may have their own form which should include at a minimum, the date when the exam was given and the Dentist's signature.

If your child is enrolled in Medicaid, CHIP, or any other dental insurance plan, the exam will be paid for by them. If your child needs insurance, please visit WVinRoads at *https://www.wvinroads.org/selfservice/* to see if you qualify for Medicaid or CHIP. If your child has already received their dental examination, please ask your child's Dentist to provide you with proof in the form of the date when the exam was given and the Dentist's signature. In order for the school to assist with follow-up care coordination, it would be beneficial if the information indicated the need for additional dental work.

If you have any questions about the requirements, need assistance with finding a Dentist or coverage for exam cost please contact **Lisa Cunningham, Director of Health Services, (304) 372-7309.**

Student Oral Health Form

Patient Information

Child's Name (Last, First, MI) _____ Date of Birth (MM/DD/YYYY) _____ Age _____

Address _____ City _____ State _____ Zip Code _____

Guardian _____ Phone _____

Oral Health Service

Please provide date of service in applicable box below:

	School Entry	2nd Grade	7th Grade	12th Grade
Date of service				

Current Oral Health Services:
Type of Services Provided? ☐ Examination

Does the child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Additional Information

_____

_____

_____

_____

Oral Health Provider's Contact Information and Signature

Provider Name (please print) _____ Phone Number _____ Fax Number _____

Practice Name _____ Address _____

Provider Signature _____ Office Contact email _____

FERPA/HIPAA CONSENT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN DENTAL/ MEDICAL PROVIDERS and SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____ _____ _____ _____
Last First MI DOB

I, the undersigned, do hereby authorize (name of agency, dental and/or health care providers):
(1) _____ (2)
to provide health information from the above-named child's dental and/or medical record to and from:

_____ _____
School District to Which Disclosure is Made Address / City and State / Zip Code

_____ _____
Contact Person at School District Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

_____

Requested information shall be limited to the following:
All minimum necessary health information; or Disease-specific information as described:

DURATION:
This authorization shall become effective immediately and shall remain in effect until_____(enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS:
Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:
I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/ persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.

RE-DISCLOSURE:
I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

_____ _____ _____
Printed Name Signature Date

_____ _____
Relationship to Patient/Student Area Code and Telephone