

# DENTAL EXAMINATION FORM - INSTRUCTIONS

## CONSENT (Caregiver is a Foster Parent, Relative, Group Home, or FFA)

Consent of the parent or guardian (via the DCFS 179) or court authorization must be obtained prior to having the child undergo any dental screenings and examinations. CSWs or Caregivers must inform the parents of the date, time and location of the exam, and inform the parent of the opportunity to be present. It is not necessary to reschedule the exam if the parent does not respond or if the parent cannot attend. Notice may be provided verbally, by text, email, mail, in-person, or voicemail. The exam must be rescheduled under either of the following circumstances:

- The parent objects to the exam, even if the parent previously gave consent
- The parent never signed the DCFS 179 providing consent or there is no court order for the exam.

## MEDICAL RECORD PROCEDURES FOR FOSTER CAREGIVERS

The HEALTH & EDUCATION PASSPORT (HEP) BINDER accompanies each child at the time of placement. The Children's Social Worker (CSW) will review the HEP BINDER with you at each visit. The Health and Education Passport must be taken to all dental visits, including the initial examination. The health care provider must record all current dental services and tests on the DCFS 561(b). Please add completed forms to the child's HEP BINDER. If the child is removed from your care, the child's complete HEP BINDER, containing all health care documents, must be returned to the CSW *at the time of removal*, as the HEP BINDER must accompany the child upon replacement.

**Immediately notify the child's CSW (or Supervising CSW, if the CSW is unavailable) when there is any change in the child's dental health that required urgent care.**

All foster children must be referred directly to a dentist, as follows:

- Beginning at age one (1).
- At any age if a problem is suspected or detected.
- Every six (6) months for maintenance of oral health.
- Every three (3) months for children with documented special health care needs when their medical or oral condition can be affected and for other children at high risk for dental caries.

**To be completed by CSW/Caregiver - Please print legibly.**

Child needs dental examination within thirty (30) days of initial placement.

Child does not need dental examination because child had a dental examination within six (6) months of placement.

Child needs dental examination by \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ CASE#: \_\_\_\_\_ DATE PLACED: \_\_\_\_\_

CAREGIVER: \_\_\_\_\_ Phone: \_\_\_\_\_ FFA: \_\_\_\_\_ Phone: \_\_\_\_\_

CSW: \_\_\_\_\_ File#: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Data entered into CWS/CMS by: (Name) \_\_\_\_\_ Date: \_\_\_\_\_**

## **DENTAL EXAMINATION FORM** (To be completed by Dentist.)

Date of Dental Examination: \_\_\_\_\_ Name of Dentist: \_\_\_\_\_

Bi-Annual Required Examination  Condition and treatment were explained to the caregiver and child/youth (as age appropriate).

Other/Follow-Up Visit  Youth may self administer his/her own medication with **adult** supervision.

Dentist's own exam form is attached.  Youth is authorized to self administer his/her own medication.

If not attached, complete below.

**Dental Exam results:** (Treatment given; Medications Prescribed. Please attach copies of supporting documentation; test results, etc.)

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(May be continued on additional pages if necessary. If so, provider to include child's name and DOB, and sign and date additional pages.)

If follow-up care indicated, specify: \_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_ (Date) \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

(Signature Stamp Required)

# DENTAL EXAMINATION FORM - INSTRUCTIONS

## FOR STAFF USE ONLY

*Conclusion (Assessment of what happened and why):*

*Print Name*

*Signature*

*Date and Time*

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*Supervisor's Remarks (including administrative follow-up):*

*Print Name*

*Signature*

*Date and Time*

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*Distribution:*

	<i>Name of Person Contacted</i>	<i>Telephoned (Date)</i>	<i>E-mail/Mail/Fax (Date)</i>
Parent(s)/Guardian			
County Worker			
Licensing			
Monitor			
Child Abuse Report			
Police Department Report No.			
Copy for Home File			
Other:			