Race ☐W ☐B ☐A ☐H ☐AI ☐N ☐O

SCHOOL SEALANT PROGRAM

Child ID # _____ Event/Site Name _____

Grade: _____ DOB _____ Age ____ Gender: ☐ Male ☐ Female Special Health Care needs? ☐No ☐Yes

Medicaid Status: ☐Medicaid ☐HealthWave ☐No Insurance ☐Unknown ☐Private Insurance

Screening- D=decay, F=filled, M=missing, S=sealant present, PS= prescribe sealant, RS=recommend reseal, no mark= no tx recommended

#2	#3	#4	#5	#12	#13	#14	#15	**Date:**
								Treatment Plan ☐ Prophy ☐ Fluoride ☐ Sealants
#31	**#30**	**#29**	**#28**	**#21**	**#20**	**#19**	**#18**	

Provider's/Evaluator's Signature _____

Comments/Notes:

_____

_____

_____

Untreated Decay: ☐ No ☐ Yes Caries Experience: ☐ No ☐ Yes Sealants Present ☐ No ☐ Yes

Treatment Urgency: ☐ No obvious problems ☐ Early dental care ☐ Urgent Care

Decayed or filled teeth: 1st molars _____ 2nd Molars_____ Referred for treatment ☐ No ☐ Yes

Parent Contacted: ☐No ☐Yes Results:_____

Preventive Services- Mark the teeth/tooth surfaces where sealants were placed with an S

#2	#3	#4	#5	#12	#13	#14	#15	**Date:**
								Tx Provided: ☐ Fl Varnish ☐ Fl other ☐ Prophy ☐ Sealants
#31	**#30**	**#29**	**#28**	**#21**	**#20**	**#19**	**#18**	

Provider's/Evaluator's Signature _____

Comments/Notes:

_____

_____

_____

Number of teeth sealed: 1st molars _____ 2nd molars_____ Other_____

Follow up- (6 months -1 year) Mark teeth/tooth surfaces where sealants are retained with an R

#2	#3	#4	#5	#12	#13	#14	#15	**Date:**
								Tx Provided: ☐ Replaced Sealants
#31	**#30**	**#29**	**#28**	**#21**	**#20**	**#19**	**#18**	

Provider's/Evaluator's Signature _____

Comments/Notes:

_____

_____

_____

Number of teeth retaining a program sealant:#_____ Subsequent visit for restorative TX: ☐No ☐Yes ☐ Unknown

Kansas Department of Health and Environment

Kansas Bureau of Oral Health