Dear Dentist,

All infants/children enrolled in the CAI Early Head Start program are required to have a dental exam in accordance with the EPSDT guidelines.

According to the Massachusetts’ EPSDT Dental Protocol and Periodicity Schedule, a child’s “first examination should occur at the eruption of the first tooth and no later than 12 months old.” Exams should be repeated every six months or as indicated by the child’s risk status/ susceptibility to disease.

Please take the time to fully complete all sections of the attached form including oral exam, dental needs and treatment plan (if needed), as well as the date of the next appointment. The form must also be signed and dated.

Please feel free to call me if you have any questions. I may be reached at (978) 372-5052 ext. 201. Thank you for your assistance in meeting our federal mandates.

Sincerely,

David Marley
(Early Head Start Health & Nutrition Specialist)

PY 2013-2014

“...in the business of caring since 1965”
An Equal Opportunity Agency
Head Start Center ______________________ Class ______________________
Child’s Name ________________________ Sex _________ Date of Birth __________
Address ______________________________ Apt. _______ City ___________________________
Parent/Guardian ________________________ Work # _______________ Home # _____________

Is this the child’s first dental visit? □ Yes □ No Does the child use a bottle? □ Yes □ No
Does the child use a pacifier? □ Yes □ No When does the child brush his/her teeth? ___________________________

Oral Examination: Date of Exam: __________________________

Child received the following: (Check all that apply)
☐ Prophylaxis ☐ Fluoride Treatment ☐ X-rays ☐ Sealants

Oral Hygiene
☐ Good
☐ Fair
☐ Needs Improvement

<table>
<thead>
<tr>
<th>Normal</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soft Tissue</td>
<td>Lips</td>
</tr>
<tr>
<td></td>
<td>Tongue</td>
</tr>
<tr>
<td></td>
<td>Gingiva</td>
</tr>
<tr>
<td>Hard Palate</td>
<td></td>
</tr>
<tr>
<td>Occlusion</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Dental Examination Reveals:
Please Check:

☐ No treatment needed at present time
☐ Restorative treatment is needed
☐ Follow-up treatment is completed

An appointment has been made: □ Yes □ No
If yes, Date of Next appointment:
Month_______________ Day ______________

Treatment Plan

Remarks:

Dentist’s Signature: ________________________ Date of Oral Exam: ___________
Address: ___________________________________ Phone: _______________________
Dentist’s Name (please print) ____________________________