

Dental Exam Form
Unaccompanied Children's Program
Office of Refugee Resettlement (ORR)

General Information

Minor	Last name: _____		First name: _____	
	DOB: ____/____/____		A#: _____	
Dental Provider	Name: _____		Phone number: _____	
	Street address: _____		Clinic or Practice: _____	
	City or Town: _____		State: _____	
Program	Program name: _____		Date of visit: ____/____/____	
	<input type="checkbox"/> Program Staff Member Present During Exam with Dental Provider			

Dental History

Concerns Expressed by Minor or Caregiver:

Diagnosis and Plan

Diagnosis: Minor with complaints, symptoms, diagnoses/conditions; meds prescribed (including OTC) or referrals needed:
 Yes, check all diagnoses that apply. Specify in the space provided, where indicated.

- Broken tooth or teeth
- Impacted tooth/teeth
- Tooth decay/Caries, specify how may: _____
- Other, specify: _____
- Gingivitis/Gum disease
- Infection/Abscess
- Tooth sensitivity

Plan: Check all that apply and specify in the space provided.

- Return to clinic: PRN/As needed Follow-up (specify condition, timing): _____
- Minor fit to travel: No Yes: _____
- Per program staff, discharge from ORR custody will be delayed: No Yes: _____
- Minor has/may have an ADA disability: No Yes: _____
- Referred to specialist: _____
- Medications given (specify name, reason, date started, dose, and directions and indicate if psychotropic):

- Dietary restrictions: _____
- Surgery/procedure needed/performed: _____
- Other: _____

Recommendations from Healthcare Provider / Additional Information

Dental Provider Signature: _____ **Date:** ____/____/____

Dental Provider Printed Name: _____

The purpose of this information collection is to provide ORR with critical health information for unaccompanied children in the care of ORR. Public reporting burden for this collection of information is estimated to average 5 minutes per healthcare provider, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. This is a mandatory collection of information (6 U.S.C. §279; Exhibit 1, part A.2 of the Flores Settlement Agreement (Jenny Lisette

Flores, et al., v. Janet Reno, Attorney General of the United States, et al., Case No. CV 85-4544-RJK [C.D. Cal. 1996]). An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information subject to the requirements of the Paperwork Reduction Act of 1995, unless it displays a currently valid OMB control number. The OMB # is 0970-0466 and the expiration date is **XX/XX/XXXX**. If you have any comments on this collection of information, please contact UACPolicy@acf.hhs.gov.