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					ssessment							
				_	ed Children		~					
			Office o		ee Resettle ral Informatio		(OKK)					
	Last name	e:		Cerre		t name:	:					
Child	DOB:		A#:		Gender:		Date evaluated:		Time evaluated:			
	Primary la	anguage:		Who provided appropriate language services for child during evaluation?					• Trained • Not interpreter provide		ided	
	Name:				ne number:			Clinic or Pra	ctice:			
Dental Provider												
	Street address:			City/Town:				State:				
Program	Program	m name:  • Program Staff Member Present During Exam with Dental Program Staff Member Present During Staff Member Present During Staff Member Present During Staff Member Present During Staff M						l Prov	/ider			
Reason for	Initial	Dental Exam (IDE)	Acute dental care					Oral prophylaxis				
visit:	• Follow-up for acute/chronic condition • Pre-surgical clearance											
				History	and Assessme	nt						
Allergies:	• No	Yes, specify belo	ow:		N 4 12 42				F	-4-1		
Allergen		Food		Medication				Environmental				
Reaction												
Dental & Me	dical Histo	ry (including dates &	locations of care)	:			· ·					
Surgeries:												
-												
		ditions:			<del> </del>							
Family:		- N V										
Currently pre		No Yes Past:										
frequency &		Current:										
		Child or Caregiver:		specify:								
					nosis and Plan							
		mplaints, symptoms,					_					
	tooth/ teetl ecay/Caries	,	tis/Gum disease sensitivity	1	acted tooth/tee er, specify:	eth	€ Infection/A	bscess	€ Missin	g tootn,	/teetr	1
		oly and specify where	<u> </u>			notes an	nd lah/imaging i	esults to pros	ram staff			
		althcare services rece				lotes an	id idb/imaging i	courts to proj	Statil Statil			
€ Medication	ns administe	ered/prescribed:										
Medication	name	Reason	Date starte	ed Expe	ected end date	D	ose	Direction	s	Psych	otrop	ic
										• No	• Y	/oc
										• No	• Y	_
										• No	• Y	$\overline{}$
			'	1		•						
		hcare needs that req							frame and fr	equenc	:y:	
		s (e.g., soft foods, liq										
	 mav have ar	n ADA disability:										
Child is cle	-	-										
		erns that require follo	ow-up services; spe	ecify needs	and time fram	e by wh	nen services sho	uld occur:				
	to clinic:											
<ul> <li>Special</li> </ul>	list evaluati	on:										

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<ul> <li>Surgery/Procedure needed/performed:</li></ul>									
Child cleared to travel:	<ul> <li>Yes, with no restrictions</li> <li>Yes, with restrictions (e.g., ground travel, travel safety plan):</li> <li>No, reason:</li> </ul>								
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 7 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.

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