				Dental A	ssessme	nt Form	1					
				companie								
			Office	e of Refug			: (ORR)					
	Last nam			Gene	ral Informa	tion First name	· ·					
		ie.										
Child DOB: Primary languag			A#:		Sex:		Date evaluated	:	Time evaluated:			
		language:		Who provided ervices for ch							Not provided	
Dental	Name:	Name:			Phone number:				Clinic or Practice:			
Provider Street a		ldress:			City/Town:			State:				
Program	Program	name:				• Progr	am Staff Membe	er Present Durin	ng Exam with	n Dental	l Provider	
Reason for		Dental Exam (IDE)				e dental ca			 Oral 	prophy	laxis	
visit:	Follow	-up for acute/chronic	condition			urgical cle	arance					
Allergies	• No	• Vac specify hole		Histor	y and Assess	ment						
Allergies:	• No	 Yes, specify belo Food)w:		Medication			Environmen		ntal		
Allergen												
Reaction												
		ory (including dates &										
Surgeries:												
		nditions:										
Family:												
Currently pre		• No • Yes										
Medications		Past:										
frequency &	dates):	Current:										
		Child or Caregiver:										
Diagraphic Ch	ailal suithe as		dia amagana (ao m		gnosis and P			a a a da di 🖉 a 🛛 bia			+ + + + + + + + + + + + + + + + + + + +	
E Broken t		omplaints, symptoms,	tis/Gum disease		acted tooth		€ Infection/A		 Yes, cr € Missing 			
€ Tooth de					er, specify: _		C micetion//	-D3CC33	C Missing	5 10011/	teeth	
	-	ply and specify where					nd lab/imaging	results to progr	am staff.			
Child education	ated on he	althcare services rece tered/prescribed:										
Medication	name	Reason	Date sta	arted Exp	ected end da	ite [Dose	Directions		Psycho	otropic	
										• No	• Yes	
										• No	• Yes	
										• No	• Yes	
			•		I							
Dietary	restriction	thcare needs that req ns (e.g., soft foods, liqu						n/reason, time f	rame and fr	equenc	y:	
Child has/may have an ADA disability: Child is cleared for surgery												
 Child has health concerns that require follow-up services; specify needs and time frame by when services should occur: Return to clinic:												
Specialist evaluation:												

 Surgery/P 	rocedure needed/performed:			
• Other, sp	ecify:			
Child cleared to travel:	 Yes, with no restrictions Yes, with restrictions (e.g., ground travel, travel safety plan): 			
	No, reason:			
Recommendati	ons from Healthcare Provider / Additional Information			
Dental Provide	r Signature:	Date:	/	/
Dental Provide	r 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 10/31/2026. If you have any comments on this collection of information, please contact <u>UACPolicy@acf.hhs.gov</u>.

OMB Control No: 0970-0466 Expiration date: 10/31/2026