DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-40303 (10/2025)

STATE OF WISCONSIN

EARLY CHILDHOOD CARIES PREVENTION SCREENING

Participation is voluntary, information collected on this form will be used for tracking treatment, and services provided to the patient and will be used only for this purpose. See instructions below.

Date of Screening (mm/dd/yyyy)	**Site**	**Initials - Screener**

PARTICIPATION INFORMATION

Identification Number	**Birth Date (mm/dd/yyyy)**	**Age**

Gender	**Race and Ethnicity**		
1=Male	1=White	5= American Indian/Alaska Native	
2= Female	2=African-American	6=Native Hawaiian/Pacific Islander	
	3=Hispanic	7=Multi-racial	
	4=Asian	9=Unknown	

Untreated Caries	**Caries Experience**
0=No untreated cavities	0=No caries experience
1=Untreated cavities	1=Caries experience
Early Childhood Caries	**Treatment Urgency**
0=No ECC	0=No obvious problem
1=ECC present	1=Early dental care
	2=Urgent care
Child has Special Health Care Needs	**Specify needs (optional):**
0=No	
1=Yes	

Comments

Fluoride Varnish Prescription	**Fluoride Varnish Applications**
Dosage: **Application Schedule:**	
☐ .25ml (preschool)	1. Application Date _____Provider Initials_____
☐ .40ml (school aged)	2. Application Date _____Provider Initials_____
	3. Application Date _____Provider Initials_____
_____	
SIGNATURE – Prescriber	

INSTRUCTIONS

1. The **Site** is the name of the agency.
2. The **Identification Number** i.e., patient record number
3. Please refer to Basic Screening Surveys: An Approach to Monitoring Community Oral health, 1999, ASTDD, for completing the PARTICIPANT INFORMATION section of the form.

Address any questions to:

DEPARTMENT OF HEALTH SERVICES
Division of Public Health State
Dental Hygiene Officer
201 E Washington Ave Room E100
Madison WI 53702