Policy on Mandatory School-entrance Oral Health Examinations

Originating Council
Council on Clinical Affairs

Review Council
Council on Clinical Affairs

Adopted
2003

Revised
2008

Purpose

The American Academy of Pediatric Dentistry (AAPD) encourages policy makers, public health and education officials, and the dental community to recognize that poor oral health can affect a child's ability to learn. An oral examination prior to matriculation into school could improve school readiness by providing a timely opportunity for diagnosis and treatment of oral conditions.

Methods

This policy is based on a review of current dental and medical literature, including the US Surgeon General's report "Oral Health in America",[1] as well as policies and guidelines established by stakeholders in the health and education of our nation's children. Data is not available to determine the effectiveness of various approaches by states that currently encourage school-entry dental examinations.

Background

Professional care is necessary to maintain oral health.[1] The AAPD "emphasizes the importance of initiating professional oral health intervention in infancy and continuing through adolescence and beyond. The periodicity of professional oral health intervention and services is based on a patient's individual needs and risk indicators."[2] The American Academy of Pediatrics recommends that, beginning at age 3, a child's comprehensive health assessment should include attention to problems that might influence school achievement.[3] General health examinations prior to school entrance are mandated by many states. Integration of general health and oral health care programs is lacking.[1] Only 6 states and Washington, DC require a dental examination prior to school matriculation. In the United States, many children have not received a professional oral health assessment prior to entering kindergarten.[1] While laws may not guarantee that every child will be examined by a dentist, they do increase the likelihood of this happening.

Caries is the most common chronic disease of childhood.[1] Caries and gingivitis can be prevented and eradicated, but not everyone is aware of the measures necessary to do so. More than one third of the population of the United States does not benefit from community water fluoridation.[1,4] Because the use of fluoride contributes to the prevention, inhibition, and reversal of caries,[5,6] early determination of a child's systemic and topical fluoride exposure is important. A dental home provides the necessary diagnostic, preventive, and therapeutic practices, as well as ongoing risk assessment and education, to improve and maintain the oral health of infants, children, and adolescents.[7,8] To maximize effectiveness, the dental home should be established within 6 months of eruption of a child's first tooth and no later than his/her first birthday.[9]

The public's lack of awareness of the importance of oral health is a major barrier to dental care.[1] Oral health is integral to general health. Oral conditions can interfere with eating and adequate nutritional intake, speaking, self-esteem, and daily activities.[10] Children with early childhood caries may be severely underweight because of associated pain and the disinclination to eat. Nutritional deficiencies during childhood can impact cognitive development.[10,11] Rampant caries is one of the factors causing insufficient development in children who have no other medical problems.[12] Unrecognized disease and postponed care result in exacerbated problems, which lead to more extensive and costly treatment needs. Early recognition and intervention could result in savings of health care dollars for individuals, community health care programs, and third-party payors.

The National Association of State Boards of Education recognizes "health and success in school are interrelated. Schools cannot achieve their primary mission of education if students and staff are not healthy and fit physically, mentally, and socially."[13] Children with dental pain may be irritable, withdrawn, or unable to concentrate. Pain can affect test performance as well as school attendance.[10] In 1996, students aged 5 to 17 missed an average of 3.1 days/100 students due to acute dental problems.[10] When these problems are treated and children no longer are experiencing pain, their learning and school attendance improve.[10]

According to the US Surgeon General, "a national public health plan for oral health does not exist."[14] Profiles on state and local populations, although rarely available, are necessary for planning oral health care programs. Descriptions of requirements for oral health examinations (oral health indicators), implementation/enforcement of regulations, and administrative disposition of collected data vary both among and within states that encourage dental examinations prior to school matriculation.

Policy statement

Early detection and management of oral conditions can improve a child's oral health, general health and well-being, and school readiness. Recognizing the relationship between oral health and education, the AAPD supports legislation mandating a comprehensive oral health examination by a qualified dentist for every student prior to matriculation into school. The examination should be performed in sufficient detail to provide meaningful information to a consulting dentist and/or public health officials. This would include documentation of oral health history, soft tissue health/pathologic conditions, oral hygiene level, variations from a normal eruption/exfoliation pattern, dental dysmorphology or discoloration, caries (including white-spot lesions), and existing restorations. The examination also should provide an educational experience for both the child and the parent. The child/parent should be made aware of age-related caries-risk and caries-protective factors, as well as the benefits of a dental home. Because a child's risk for developing dental disease changes and oral diseases are cumulative and progressive, the AAPD also supports such legislation to include subsequent comprehensive oral examinations at periodic intervals throughout the educational process. In addition, the AAPD encourages state and local public health and education officials, along with other stakeholders, such as health care providers and dental/medical organizations, to document oral health needs, work toward improved oral health and school readiness for all children, and address related issues such as barriers to oral health care. The AAPD recognizes that, without appropriate follow-up care, requiring oral health examinations is insufficient to ensure school readiness. Thus, the AAPD encourages local leaders to establish a referral system to help parents obtain needed oral health care for their children. The AAPD opposes regulations that would prevent a child from attending school due to noncompliance with mandated examinations.

References

1. US Dept of Health and Human Services. Oral health in America: A report of the Surgeon General. Rockville, Md: US Dept of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health; 2000.
2. American Academy of Pediatric Dentistry. Guideline on periodicity of examination, preventive dental services, anticipatory guidance, and oral treatment for children. Pediatr Dent 2007;29(suppl):102-8.
3. American Academy of Pediatrics. School health assessment. Pediatrics 2000;105(4Pt1):875-7.
4. National Center for Fluoridation Policy and Research. University of Buffalo School of Dental Medicine. Available at: "http://www.fluoride.oralhealth.org". Accessed December 23, 2007.
5. CDC. Recommendations for using fluoride to prevent and control dental caries in the United States. MMWR Recomm Rep 2001;50(RR14):1-42.
6. Burt B, Eklund S. Dentistry, Dental Practice, and the Community. Philadelphia, Pa: WB Saunders Company; 1999.
7. American Academy of Pediatric Dentistry. Policy on the dental home. Pediatr Dent 2007;29(suppl):22-3.
8. Poland C. Pediatric oral health. In: Burns CE, Brady MA, Dann AM, Starr N, eds. Pediatric Primary Care: A Handbook for Nurse Practitioners. 2nd ed. Philadelphia, Pa: WB Saunders Co; 2000.
9. American Academy of Pediatric Dentistry. Guideline on infant oral health care. Pediatr Dent 2007;29(suppl):81-4.
10. National Center for Education in Maternal and Child Health and Georgetown University. Fact sheet: Oral health and learning. Arlington, Va: NCEMCH; 2001.
11. Center on Hunger, Poverty, and Nutrition Policy. Statement on the link between nutrition and cognitive development in children. Medford, Ma: Tufts University, Center on Hunger, Poverty, and Nutrition Policy; 1998, 4th ed.
12. Acs G, Lodolini G, Kaminsky S, Cisneros GJ. Effect of nursing caries on body weight in a pediatric population. Pediatr Dent 1992;14(5):302-5.
13. Bogden JF, Vega-Matos CA. Fit, healthy, and ready to learn: A school health policy guide, part 1: Physical activity, healthy eating, and tobacco-use prevention. Alexandria, Va: National Association of State Boards of Education; 2000.
14. US Dept of Health and Human Services. Oral health in America: A report of the Surgeon General–Executive summary. Rockville, Md: US Dept of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health; 2000:12.