

## PROOF OF SCHOOL DENTAL EXAMINATION FORM

## To be completed by the parent (please print):

Student's Nar	me:	Last	First	Middle	Birth Date: (Month/Day/Year)
Address:	Street		City	ZIP Code	Telephone:
Name of Scho	ool:			Grade Level:	Gender:
Parent or Guardian:				Address (of parent/guard	□ Male □ Female dian):
To be completed by dentist:					
Oral Health Status (check all that apply)					
□ Yes □ No	o <b>Dental</b>	Sealants Pres	ent		
☐ Yes ☐ No	Caries Experience / Restoration History — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.				
□ Yes □ No	□ No Untreated Caries — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.				
□ Yes □ No	o <b>Soft Ti</b>	ssue Patholog	у		
□ Yes □ No	o <b>Maloco</b>	lusion			
Treatment Needs (check all that apply)					
☐ <b>Urgent Treatment</b> — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling					
☐ <b>Restorative Care</b> — amalgams, composites, crowns, etc.					
□ Preventive Care — sealants, fluoride treatment, prophylaxis					
□ Other — periodontal, orthodontic					
Please note					
Signature of Dentist				Date of Ex	am
Address	Street		City Z	Telephone Telephone	

Illinois Department of Public Health, Division of Oral Health 217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

