Whitesboro Central School District

65 Oriskany Blvd. Suite 1 • Whitesboro, NY 13492 • www.wboro.org

High School: 315.266.3200 | **Middle School:** 315.266.3100 | **Parkway School:** 315.266.3176
Deerfield Elementary: 315.266.3410 | **Hart's Hill Elementary:** 315.266.3430
Marcy Elementary: 315.266.3420 **Westmoreland Road Elementary:** 315.266.3440

Date: ___/___/___ (MM DD YYYY)

Dental Health Certificate - Optional

Parent/Guardian: New York State Law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 1, 3, 5, 7, 9, 11. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section I and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section II.

Return the completed form to your child's school as soon as possible.

SECTION I TO BE COMPLETED BY PARENT OR GUARDIAN:

Last Name:	First Name:	Middle Name:
Date of Birth: ___/___/___ (MM DD YYYY)	Gender: Male Female	Will this be your child's first oral health assessment? Yes No
School Name:		Grade: Choose One

Have you noticed any oral problems that interfere with your child's ability to chew, speak or focus on school activities? Yes No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays, if necessary, to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

_____
Parent/Guardian Name *(please print):*

_____ **Date:** ___/___/___ (MM DD YYYY)
Parent/Guardian Signature:

SECTION II ITEMS 1-3 TO BE COMPLETED BY THE DENTIST/DENTAL HYGIENIST:

1. The dental health condition of _____ (Name of child) on ___/___/___ (MM DD YYYY) (date of assessment)

The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

Yes, The student listed above is in fit condition of dental health to permit his/her attendance at public schools.

No, The student listed above is not in fit condition of dental health to permit his/her attendance at public schools.

NOTE: *"Not in fit condition of dental health" means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of "not in fit condition of dental health to permit attendance at public schools" does not preclude the student from attending school.*

Dentist's Office Name:	_____ **Dentist's/Dental Hygienist's Name** (*please print*)**:**
Dentist's Office Address:	_____ **Dentist's/Dental Hygienist's Signature:**

PLEASE FILL OUT STUDENT NAME FIELDS IN THE EVENT THAT THE PAGES OF THIS FORM BECOME DETACHED.

STUDENT LAST NAME:	STUDENT FIRST NAME:

SECTION II CONTINUED - ITEMS 1-3 TO BE COMPLETED BY THE DENTIST/DENTAL HYGIENIST:

Optional Information - Parent/Guardian, if you agree to release this information to your child's school, please initial in the box to the right.

INITIAL HERE

2. Oral Health Status:

Yes No **Caries Experience/Restoration History -** Has the child ever had a cavity (treated or untreated)?
[A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

Yes No **Untreated Caries** - Does this child have an open cavity? [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 pits 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 **Dental Sealants Present**

Other problems (Specify):

Optional Information - Parent/Guardian, if you agree to release this information to your child's school, please initial in the box to the right.

INITIAL HERE

3. Treatment Needs:

No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.