



Health and Wellness Services

School Entry Dental Examination

Student's name _____
(Last) (First) (M.I.)

Birth Date ____/____/____

Street address _____

City/Zip _____

School _____

Dentist's name _____

THE FOLLOWING TO BE COMPLETED BY EXAMINING DENTIST

1. Untreated decay in deciduous teeth YES NO
2. Untreated decay in permanent teeth YES NO

If yes, to 1 or 2, please answer a, b, and c below.

- a. Decay is classified as early childhood caries/baby bottle caries (affecting the primary maxillary anterior teeth, followed by involvement of the primary molars; mandibular incisors may not be affected) YES NO
- b. Decay is classified as rampant caries in permanent teeth YES NO
- c. Child is experiencing pain *and/or* infection YES NO
3. Occlusion is within normal range for age YES NO
If no, immediate follow-up is indicated YES NO
4. Oral hygiene Optimal Needs Improvement
5. This is child's first dental treatment completed YES NO
6. All necessary dental treatment completed YES NO
If no, appointments are made for completing treatment YES NO

COMMENTS:

Dentist's signature _____

Date _____