

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Studen	t's Name	: Last	First	Middle	Birth Date: (Month/Day/Year)	
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Addres	s:	Street	City	ZIP Code	Telephone:	
Name of	of Schoo	l:		Grade Level:	Gender:	
					☐ Male ☐ Female	
Parent or Guardian: Ad				Address (of parent/guard	Address (of parent/guardian):	
To be completed by dentist:						
Oral Health Status (check all that apply)						
□ Yes	□ No	Dental Sealants Present				
☐ 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	Yes 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 retain root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are contained as a cavitated lesion is also present.					
□ Yes	□ No	Soft Tissue Patholog	зу			
□ Yes	□ No	Malocclusion				
Treatment Needs (check all that apply)						
□ Urgent Treatment — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling						
☐ Restorative Care — amalgams, composites, crowns, etc.						
□ Preventive Care — sealants, fluoride treatment, prophylaxis						
☐ Other — periodontal, orthodontic						
Please note						
Signature of Dentist				Date of Exa	ım	
Address	S	Street	City Z	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

