

## PROOF OF SCHOOL DENTAL EXAMINATION FORM

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

Student's Nam	ne: Last	First	Middle	Birth Date: (Month/Day/Year)	
				1 1	
Address:	Street	City	ZIP Code	Telephone:	
Name of Scho	ol:		Grade Level:	Gender:  □ Male □ Female	
Parent or Guardian:			Address (of parent/guard	Address (of parent/guardian):	
To be comple	eted by dentist:				
Oral Health S	Status (check all that ap	ply)			
□ 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 □ No	<b>Untreated Caries</b> — 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	Soft Tissue Patholog	у			
□ Yes □ No	Malocclusion				
Treatment Ne	eds (check all that app	ly)			
☐ Urgent Tı	reatment — abscess, nerve	exposure, advanced disease	state, signs or symptoms that include	pain, infection, or swelling	
□ Restorati	ve Care — amalgams, com	posites, crowns, etc.			
□ Preventiv	re Care — sealants, fluoride	treatment, prophylaxis			
□ Other —	periodontal, orthodontic				
Please no	te				
Signature of D	Dentist		Date of Exa	ım	
Address			Telephone		
	Street	City Z	IP Code		

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

