

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Nam	e: Last	First	Middle	Birth Date: (Month/Day/Year)	
Address:	Street	City	ZIP Code	Telephone:	
Name of School:			Grade Level:	Gender: □ Male □ Female	
Parent or Guardian:			Address (of parent/guard	Address (of parent/guardian):	
To be comple	eted by dentist:				
Oral Health Status (check all that apply)					
□ Yes □ No	Dental Sealants F	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 1 st 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	Soft Tissue Patho	ology			
□ Yes □ No	Malocclusion				
Treatment No	eds (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	Date of Exam	
Address			Telephone		
	Street	City Z	ZIP 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

