

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name	e: Last	First	Middle	Birth Date: (Month/Day/Year)
				1 1
Address:	Street	City	ZIP Code	Telephone:
Name of School:		Grade Level:	Gender:	
				☐ Male ☐ Female
Parent or Guardian:			Address (of parent/guardian):	
To be comple	ted by dentist:			
Oral Health S	tatus (check all that ap	oply)		
□ Yes □ No	Dental Sealants Pres	ent		
□ 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	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 Patholog	у		
□ Yes □ No	Malocclusion			
Treatment Ne	eds (check all that app	oly)		
☐ Urgent Tr	eatment — abscess, nerve	exposure, advanced disease	state, signs or symptoms that include	pain, infection, or swelling
☐ Restorativ	ve Care — amalgams, com	posites, crowns, etc.		
☐ Preventiv	e Care — sealants, fluoride	treatment, prophylaxis		
□ Other — p	periodontal, orthodontic			
Please no	te			
Signature of D	Pentist		Date of Exa	am
Address	Street		Telephone	
	Street	City	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

