

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Studer	nt's Name	e: Last	First	Middle	Birth Date: (Month/Day/Year)	
Addres	ss:	Street	City	ZIP Code	Telephone:	
Name of School:				Grade Level:	Gender: □ Male □ Female	
Parent or Guardian:				Address (of parent/guardian):		
To be completed by dentist:						
Oral H	ealth St	atus (check all that ap	ply)			
□ Yes	□No	Dental Sealants Present				
□ Yes	Yes On 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 walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retaroot, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are content of the property of the pr					smooth tooth surfaces. If retained	
□ Yes	□ No	Soft Tissue Patholog	у			
□ Yes	□ No	Malocclusion				
Treatm	ent Nee	eds (check all that app	ly)			
□ Ur	gent Tre	eatment — abscess, nerve	exposure, advanced disease s	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						
Ple	ease note	e				
Signati	ure of De	entist	Date of Exa	am		
Addres		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

