

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name:	Last	First	Middle .	Birth Date: (Month/Day/Year) / /
Address: Stree	et	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 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 🛛 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 Pathology
- □ 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	

Address _

Date of Exam

Address				Telephone			
	Street	City	ZIP Code				
Illinois Department of Public Health, Division of Oral Health							
	217-785-48	899 🔹 TTY (hearing impai	red use only) 800-547	-0466 • www.idph.state.il.us			