HEALTH SERVICES DEPARTMENT

School Entry Dental Examination

Student's name _____ Birth date ____/____/____
(last) (first) (initial)

Street address _____

City/ZIP _____

School _____

Dentist's name _____ Dentist's phone number _____

THE FOLLOWING TO BE COMPLETED BY EXAMINING DENTIST:

1. Untreated decay in deciduous teeth ☐ yes ☐ no

2. Untreated decay in permanent teeth ☐ yes ☐ no

If yes, to 1 or 2 above, please answer a, b and c below.

a. Decay is classified as *early childhood caries/babybottle caries* (affecting the primary maxillary anterior teeth, followed by involvement of the primary molars; mandibular incisors may not be affected) ☐ yes ☐ no

b. Decay is classified as rampant caries in permanent teeth ☐ yes ☐ no

c. Child is experiencing pain *and/or infection* ☐ yes ☐ no

3. Occlusion is within normal range for age ☐ yes ☐ no

If no, immediate follow-up is indicated ☐ yes ☐ no

4. Oral hygiene ☐ optimal ☐ needs improvement

5. This is child's first dental examination ☐ yes ☐ no

6. All necessary dental treatment completed ☐ yes ☐ no

If no, appointments are made for completing treatment ☐ yes ☐ no

COMMENTS:

Dentist's signature _____ Date _____

Revised 3/2014