

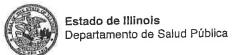
PROOF OF SCHOOL DENTAL EXAMINATION FORM

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 | ol; | | Grade Level: | Gender: ☐ Male ☐ Female | | |
| Parent or Guardian: | | | Address (of parent/guard | Address (of parent/guardian): | | |
| | | | | | | |
| _ | ted by dentist: | | | | | |
| Oral Health S | tatus (check all that a | pply) | | | | |
| □ Yes □ No | Dental Sealants Pre | sent | | | | |
| □ 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 Patholo | ду | | | | |
| □ Yes □ No | Malocclusion | | | | | |
| Treatment Ne | eds (check all that ap | ply) | | | | |
| ☐ Urgent Tree | eatment — abscess, nerv | e exposure, advanced disease | state, signs or symptoms that include | pain, infection, or swelling | | |
| ☐ Restorativ | /e Care — amalgams, cor | nposites, crowns, etc. | | | | |
| ☐ Preventive | e Care — sealants, fluoride | e treatment, prophylaxis | G. | | | |
| ☐ Other — p | eriodontal, orthodontic | | | | | |
| Please not | e | | | | | |
| Signature of D | entist | | Date of Exa | ım _, | | |
| Address | | | Telephone | | | |
| | Street | City Z | IP 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





FORMULARIO COMPROBANTE DEL EXAMEN DENTAL ESCOLAR

Para ser completado por el padre/madre (por favor impresión):

| Nombre del Est | udiante: Apellido | Nombre | Inicial | Fecha de Nacimiento: / / (Mes/DIa/Año) | | | |
|--|---|-------------------------------|--|--|--|--|--|
| Dirección; | Calle | Ciudad | Código Postal | Número de Teléfono: | | | |
| Nombre de la E | scuela: | | Grado: | Sexo: Masculino Femenino | | | |
| Nombre del padre/madre o encargado: | | | Dirección del padre/madre o encargado: | | | | |
| | | | | | | | |
| To be completed by dentist: (Para ser completado por el dentista:) | | | | | | | |
| 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 Ne | eds (check all that apply) | | | | | | |
| ☐ Urgent Tro | eatment — abscess, nerve expos | sure, advanced disease state, | signs or symptoms that include pa | ain, infection, or swelling | | | |
| Restorative Care — amalgams, composites, crowns, etc. | | | | | | | |
| ☐ Preventive | e Care — sealants, fluoride treatm | nent, prophylaxis | | | | | |
| □ Other — p | eriodontal, orthodontic | | | | | | |
| Please not | e | | | | | | |
| Signature of D | entist | | Date of Exam | 1 | | | |
| Address | | | Telephone | | | | |
| , | Street City | ZIP Cod | | | | | |

Departamento de Salud Pública de Illinois, División de la Salud Oral 217-785-4899 • TTY (sólo para personas con impedimento auditivo) 800-547-0466 • www.idph.state.il.us