Illinois Department of Public Health PROOF OF SCHOOL DENTAL EXAMINATION FORM



To be completed by the parent (please print):

Student's Nan	ne: Last	First	Midd!₃	Birth Date: (Month/Day/Year)	
Address:	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 Health S	Status (check all that app	oly)			
□ Yes □ No	Dental Sealants Prese	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 1 st molars.				
□ Yes □ No	walls of the lesion. These cri	teria apply to pit and fissure ooth was destroyed by carie	ure loss at the enamel surface. Brown cavitated lesions as well as those on s. Broken or chipped teeth, plus teeth	smooth tooth surfaces. If retained	
□ Yes □ No	Soft Tissue Pathology				
□ Yes □ No	Malocclusion				
Treatment Ne	eeds (check all that appl	y)			
☐ Urgent Tr	reatment — abscess, nerve e	xposure, advanced disease	state, signs or symptoms that include	pain, infection, or swelling	
☐ Restorati	ve Care — amalgams, compo	osites, crowns, etc.		-	
☐ Preventiv	re Care — sealants, fluoride tr	eatment, prophylaxis			
☐ Other — ;	periodontal, orthodontic				
Please no	te		•		
Signature of Dentist			Date	Date	
Address			₩-11		
	Street	City Z	reiepnone _		

Illinois Department of Public Health, Division of Oral Health, 535 W. Jefferson St., Springfield, IL 62761 217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us