

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Nam	ne: Last	First	Middle	Birth Date: (Month/Day/Year)
Address:	Street	City	ZIP Code	Telephone:
Name of Scho	ol:		Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:		Address (of parent/guardian):		
To be comple	eted by dentist:			
	Status (check all that a	oply)		
□ Yes □ No	Dental Sealants Pres	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 consi ered sound unless a cavitated lesion is also present.			
□ Yes □ No	Soft Tissue Patholog	ду		
□ Yes □ No	Malocclusion			
Treatment No	eeds (check all that ap	ply)		
☐ Urgent T	reatment — abscess, nerv	e exposure, advanced disease	state, signs or symptoms that include	e pain, infection, or swelling
☐ Restorat	ive Care — amalgams, cor	nposites, crowns, etc.		
☐ Preventi	ve Care — sealants, fluorid	e treatment, prophylaxis		
□ Other —	periodontal, orthodontic			
Please no	ote			
Signature of Dentist			Date of Exam	
Address	Street		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

