Illinois Department of Public Health PROOF OF SCHOOL DENTAL EXAMINATION FORM



To be completed by the parent (please print):

Studen	t's Name	e: Last	First	Middle	Birth Date: (Month/Day/Year)	
Address	S:	Street	City	ZIP Code	Telephone:	
Name of School:				Grade Level:	Gender: ☐ Male ☐ Female	
Parent or Guardian:				Address (of parent/guardian):		
To be c	omplet	ed by dentist:				
Oral He	ealth St	atus (check all that ap	pply)			
□ Yes	□ No	Dental Sealants Pres	ent			
□ Yes	Yes \square 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	□ 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 Patholog	у			
□ Yes	□ No	Malocclusion				
Treatm	ent Nee	eds (check all that app	oly)			
□ Urg	ent Tre	eatment — abscess, nerve	exposure, advanced disease	state, signs or symptoms that include	pain, infection, or swelling	
□ Res	storativ	e Care — amalgams, com	posites, crowns, etc.			
□ Pre	ventive	e Care — sealants, fluoride	treatment, prophylaxis			
□ Oth	er — pe	eriodontal, orthodontic				
Plea	ase not	e				
Signature of Dentist				Date		
Address	S	Street	City	Telephone Telephone		

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