

Illinois Department of Public Health PROOF OF SCHOOL DENTAL EXAMINATION FORM



To be completed by the parent (please print):

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year) / /
Address:	Street	City	ZIP Code	Telephone:
Name of School:	Grade Level:			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or Guardian:	Address (of parent/guardian):			

To be completed by dentist:

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 Needs (check all that apply)

- ☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling
☐ **Restorative Care** — amalgams, composites, crowns, etc.
☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis
☐ **Other** — periodontal, orthodontic
 Please note _____

Signature of Dentist _____ Date _____
 Address _____
 Street City ZIP Code Telephone _____