Illinois Department of Public Health PROOF OF SCHOOL DENTAL EXAMINATION FORM



To be completed by the parent (please print):

Student's Name	e: Last	First	Middle	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 complet	•	andre)		
Oral Health St	atus (check all that ap	opiy)		
□ 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 Patholog	зу		
□ Yes □ No	Malocclusion			
Treatment Nee	eds (check all that app	oly)		
□ Urgent Tre	eatment — abscess, nerve	e exposure, advanced disease	state, signs or symptoms that include	pain, infection, or swelling
□ Restorativ	e Care — amalgams, com	posites, crowns, etc.		
□ Preventive	e Care — sealants, fluoride	treatment, prophylaxis		
☐ Other — pe	eriodontal, orthodontic			
Please note	e			
Signature of Dentist			Date	
Address	Other of	City Z	Telephone	
:	Street	City Z	IP Code	

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