

PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

Student's Nam	ne: Last	First	Middl	e	Birth Date: (Month/Day/Year)	
Address:	Street	City		ZIP Code		
Name of Scho	ol:	ZIP Code	Grade Leve	el:	Gender:	
ı					☐ Male ☐ Female	
Parent or Gua	rdian: Last Name		First Na	ame		
Student's Rac	e/Ethnicity:					
☐ White	☐ White ☐ Black/African American		☐ Hispanic/Latino ☐ Asia			
☐ Native Ame	erican □ Native Hawaiian/F	Pacific Islander ——] Multi-racial	☐ Unkno	wn	
To be complete	ed by dentist:					
	ecent Examination: Cleaning		neck all services provi treatment		ination date) teeth due to caries	
Oral Health St	atus (check all that apply)					
☐ Yes ☐ No	Dental Sealants Present	on Permanent Molar	'S			
☐ Yes ☐ No		aries Experience / Restoration History — A filling (temporary/permanent) OR a tooth that is missing because it was tracted as a result of caries OR missing permanent 1st molars.				
☐ Yes ☐ No	Untreated Caries — At lea walls of the lesion. These crit root, assume that the whole to considered sound unless a care	eria apply to pit and fissu ooth was destroyed by ca	re cavitated lesions as w aries. Broken or chipped	ell as those on smo	ooth tooth surfaces. If retained	
☐ Yes ☐ No	Urgent Treatment — absorbutelling.	ess, nerve exposure, adv	vanced disease state, sig	gns or symptoms th	at include pain, infection, or	
Treatment Nee	eds (check all that apply). Fo	or Head Start Agencies,	please also list appoin	ntment date or dat	e of most recent treatment	
Restorative Care — amalgams, composites, crowns, etc.		tes, crowns, etc.	Appointment Date:			
☐ Preventive Care — sealants, fluoride treatment, prophylaxis		tment, prophylaxis	Appointment Date:			
Pediatric Dentist Referral Recommended		ded	Treatment Completion Date:			
Additional cor	mments:					

Illinois Department of Public Health, Division of Oral Health 217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

