

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) MM / DD / YYYY
Address:	Street	City	ZIP Code	Telephone:
Name of School	ol:	·	Grade Level:	Gender:
Parent or Guardian:			Address (of parent/guardian):	
To be comple	ted by dentist:			
•	tatus (check all that ap	ply)		
□ Yes □ No	Dental Sealants Pres	ent		
□ Yes □ No	Caries Experience / F extracted as a result of carie		A filling (temporary/permanent) OR a molars.	tooth that is missing because it was
□ Yes □ No	walls of the lesion. These c	riteria apply to pit and fissure tooth was destroyed by carie	ture loss at the enamel surface. Brow e cavitated lesions as well as those on es. Broken or chipped teeth, plus teet	smooth tooth surfaces. If retained
□ Yes □ No	Soft Tissue Patholog	у		
□ Yes □ No	Malocclusion			
Treatment Ne	eds (check all that app	ly)		
☐ Urgent Tr	eatment — abscess, nerve	exposure, advanced disease	e state, signs or symptoms that include	e pain, infection, or swelling
Restorative Care — amalgams, composites, crowns, etc.				
☐ Preventiv	re Care — sealants, fluoride	treatment, prophylaxis		
☐ Other —	periodontal, orthodontic			
Please no	te			
Signature of E	Dentist		Date of Ex	am
Address			Telephone	
Add 699	Street	City	ZIP Code	

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

