State of Illinois
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: ☐ Male ☐ 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 of Exam _____

Address _____ Telephone _____
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

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Form No. 292

CHICAGO PUBLIC SCHOOLS
Bureau of Medical and School Health Services

DENTAL EXAMINATION RECORD

STUDENT NUMBER

ISPA NUMBER

LAST NAME	FIRST	MIDDLE	BIRTH DATE	PLACE OF BIRTH - CITY AND STATE
ADDRESS			SCHOOL	GRADE
PARENT OR GUARDIAN			TELEPHONE	

TO THE PARENT:
In order to comply with the School Code of the State of Illinois, please make an early dental appointment for the above-named child. Take this form with you, have it completed by the dentist and return it to the teacher.

1. IS YOUR CHILD RECEIVING FLUORIDE TREATMENTS IN SCHOOL? ☐ Yes ☐ No Comment

2. DOES YOUR CHILD HAVE ANY MEDICAL PROBLEM THAT MAY COMPLICATE DENTAL TREATMENT? *(i.e., Allergies, Diabetes, Respiratory Difficulty, History of Rheumatic Fever, Etc.)* ☐ Yes ☐ No Explain

TO BE COMPLETED BY DENTIST:

CURRENT DENTAL STATUS OF PATIENT:

- ☐ URGENT — *(Abscess Formation, Nerve Exposure, Advanced Disease State Including Handicapped Individuals)*
- ☐ ROUTINE DENTAL CARE NEEDED — *(Alloys, Composites, Stainless Steel Crowns, Etc.)*
- ☐ PREVENTIVE DENTISTRY ONLY NEEDED — *(Prophylaxis, Fluoride Treatment, Sealants, Etc.)*
- ☐ NO TREATMENT REQUIRED
- ☐ OTHER

PATHOLOGY PRESENT

HARD TISSUE ☐ Yes ☐ No Describe

SOFT TISSUE ☐ Yes ☐ No Describe

MALOCCLUSION ☐ Yes ☐ No Type

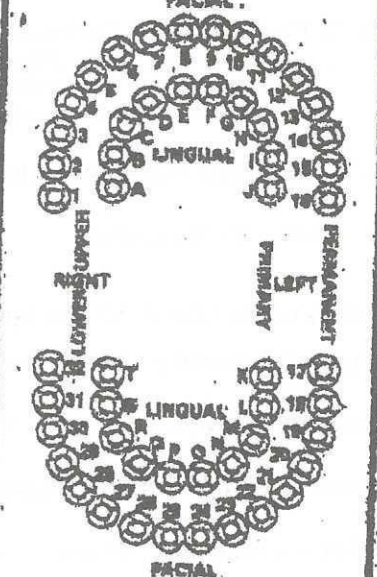
ORTHODONTIC REFERRAL RECOMMENDED ☐ Yes ☐ No

Signature of Dentist Date

Address

STREET CITY ZIP CODE

OPTIONAL



OUTLINE CARIOUS LESIONS
SLASH TEETH TO BE REMOVED
X TEETH MISSING
NOTE PATHOLOGY / LOCATION
BLOCK IN FILLINGS PRESENT

TELEPHONE

This Form is to be returned to the teacher. It becomes a part of the permanent health record.