

# 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 1<sup>st</sup> 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 \_\_\_\_\_



# DENTAL EXAMINATION WAIVER FORM

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):			

I am unable to obtain the required dental examination because:

- My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid/All Kids).
- My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/All Kids).
- My child is enrolled in Medicaid/All Kids, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid/All Kids.
- My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Signature \_\_\_\_\_

Date \_\_\_\_\_