

## PROOF OF SCHOOL DENTAL EXAMINATION FORM

## To be completed by the parent (please print):

Student	t's Nam	e: Last	First	Middle	Birth Date: (Month/Day/Year)			
Address	s:	Street	City	ZIP Code	Telephone:			
Name of School:				Grade Level:	Gender:  ☐ Male ☐ Female			
Parent	or Guar	dian:		Address (of parent/guard	Address (of parent/guardian):			
To be c	omplet	ted by dentist:						
Oral He	alth St	atus (check all that ap	ply)					
□ Yes	□ No	Dental Sealants Prese	ent					
□ 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	<b>Untreated Caries</b> — 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						
Treatme	nt Nee	eds (check all that appl	y)					
□ Urge	ent Tre	atment — abscess, nerve	exposure, advanced disease	state, signs or symptoms that include	pain, infection, or swelling			
□ Rest	torativ	e Care — amalgams, comp	osites, crowns, etc.					
□ Prev	entive	Care — sealants, fluoride t	reatment, prophylaxis					
□ Othe	er — pe	riodontal, orthodontic						
Pleas	se note	)						
Signature	e of De	entist	Date of Exa	Date of Exam				
Address	10000			Telephone				
	S	Street	City 7	IP 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



Signature

## **DENTAL EXAMINATION WAIVER FORM**



Please print:								
Student's Name:		Last	First	Middle	Birth Date: (Month/Day/Year)			
					/ /			
Ad	dress: Street	32	City	ZIP Code	Telephone:			
Name of School:				Grade Level:	Gender:			
					Male Female			
Pai	ent or Guardian:		Address (of parent/guardian):					
l am	unable to obtain the	required dental exa	amination 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.							

Date