State of Illinois
Illinois Department of Public Health

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 every 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 Name: Last First Middle Birth Date: (Month/Day/Year)

Address: Street City ZIP Code

Name of School: ZIP Code Grade Level: Gender: ☐ Male ☐ Female

Parent or Guardian: Last Name First Name

Student's Race/Ethnicity:

☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian
☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown
☐ Other: _____

To be completed by dentist:

Date of Most Recent Examination: (Check all services provided at this examination date)

☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (permanent OR baby tooth) that is missing because it was removed as a result of caries OR missing permanent first molars.

☐ Yes ☐ No **Untreated Caries** — At least 2 mm of tooth structure lost 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 more on smooth tooth surfaces. If stained, rough, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered as no unless a restorative lesion is also present.

☐ Yes ☐ No **Urgent Treatment** — abscess, nerve exposure, advanced disease, acute signs or symptoms like: recurrent pain, infection, or swelling

Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date: _____
☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date: _____
☐ **Pediatric Dentist Referral Recommended** Treatment Complete on Date: _____

Additional comments: _____

Signature of Dentist: _____ License #: _____ Date: _____