

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 any 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):

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Student's Name	: Last	First		Middle		BIM L)ate: (Month/Day/Year)
Address:	Street	t City				ZIP Code	
Name of School	;	ZIP Code		Grade Level:		Gender:	
						Male	Ö Female
Parent or Guard	ian: Last Name			First Name			
Student's Race/	Ethnicity:						
□ White	Black/African American		=	☐ Hispanic/Latino ☐ Asiai			
	□ Native American□ Native Hawaiian/Pacific Islander□ Other		□ Multi-ra] Multi-racial		own	
To be completed	by dentist:		***				
Dental C			(Check all se ide treatmen	ervices provided t	at this exam estoration of		
Oral Health Status (check all that apply)							
☐ Yes ☐ No	Dental Sealants Presen	t on Permanent Mo	olars				
☐ 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	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	Urgent Treatment — abs swelling.	cess, nerve exposure,	advanced dis	ease state, signs o	or symptoms th	nat include p	ain, infection, or
Treatment Need completion date.	s (check all that apply). F	or Head Start Agenc	ies, please al	so list appointme	nt date or dat	te of most r	ecent treatment
Restorative	Care — amalgams, compos	ites, crowns, etc.	Appoir	ntment Date:			
Preventive Care — sealants, fluoride treatment, prophylaxis		Appoir	Appointment Date:				
Pediatric Dentist Referral Recommended			Treatment Completion Date:				
Additional com	ments:						
Signature of De	entist		License	#:	Date	:	

Illinois Department of Public Health, Division of Oral Health 217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov



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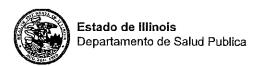


DENTAL EXAMINATION WAIVER FORM

Please print: Birth Date: (Month/Day/Year) Middle First Last Student's Name: ZIP Code City Street Address: Gender: Grade Level: ZIP Code Name of School: ☐ Male ☐ Female First Name Last Name Parent or Guardian: Student's Race/Ethnicity: ☐ Asian ☐ Hispanic/Latino ☐ Black/African American □ White □ Unknown ☐ Multi-racial ☐ Native Hawaiian/Pacific Islander ☐ Native American ☐ Other 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 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. Parent or Guardian Signature _____ Date:

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(DC)



Departamento de Salud Pública de Illinois FORMULARIO DE RENUNCIA VOLUNTARIA DEL EXAMEN DENTAL ESCOLAR (waiver)

Para ser completado por el padre/madre (por favor impresión):

Nomb estud	ore del liante:	Apellido	Nombre	Inicial	Fecha de Nacimiento: (Mes/Dia/Año)	
Direc	ción;	Calle	Ciudad		Código Postal	
Nomb Escue	ore de la ela:	Código Postal Gra		Grado:	Sexo:	
Nomb	ore del pad	dre/madre o encargado				
⊓ Blai	nco	del Estudiante: ska o Indio Americano vái o otras islas del Pacífic	□ Hispano/Latino □ Asiátic □ Afroamericano □ Multirro o			
No pu	uedo ob	tener el examen den	tal requerido porque:			
	- ') está inscrito en el prog o (Medicaid/KidCare).	rama de almuerzo gratis y co	n descuento, y no tiene r	ningún seguro dental privado	
) está inscrito en el prog d/KidCare).	rama de almuerzo gratis y co	n descuento, y no es ele	gible para un seguro público	
			aid/KidCare, pero no podemos nijo(a) y que acepte el Medicai		una clinica dental en nuestra	
		ı) no tiene ningún tipo do e pueda ver a mi hijo(a)	e seguro dental, y en nuestra :	comunidad no hay ningu	na clínica dental de bajo	
Firma				Fecha:	Was de la constant de	
			de Salud Pública de Illinois, D ólo para personas con impedi www.dph.illinois.gov			
IOCI 06	800-10		Impreso con Autoridad del Estado de	Illinois		