

**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 \_\_\_\_\_

Illinois Department of Public Health, Division of Oral Health, 535 W. Jefferson St., Springfield, IL 62761  
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

## Illinois Department of Public Health 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/KidCare).
- My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/KidCare).
- My child is enrolled in Medicaid/KidCare, 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/KidCare.
- 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 \_\_\_\_\_

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