

Proof of School Dental Examination Form

Illinois law (Child Health Examination Code, 77 III. 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 and 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 be 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.

Student's Las Name:	st	First		Middle	Birth Date (Month/Day/Year):	
Address: Str	reet		City		ZIP Code	
School: Na	me		ZIP Code	Grade Level:	Gender: Male Female	
Parent or Land						
Student's Rac White Native Ha	ce/Ethnicity: ☐ Black or African Amewaiian or Pacific Islander	erican		ian ☐ American Two or More Races	ı Indian or Alaskan Native ☐ Unknown ☐ Other	
To be compl	eted by the dentist:					
Date of Most R	Recent Examination:	(Check all serv	vices provided at th	is examination date)		
Dental Clea	aning Sealant	☐ Fluoride treatment	☐ Silver Diamin	e Fluoride	storation of teeth due to caries	
Oral Health St	tatus (check all that apply)					
☐ Yes ☐ No	Dental Sealants Presen	t on Permanent Molars				
☐ 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 first 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 — Ab	scess, nerve exposure, advance	ed disease state, sigr	ns or symptoms that includ	de pain, infection, or swelling.	
	eds (check all that apply) Agencies, please also list the	appointment date or date of the	most recent treatmen	ıt.		
Restorative Care — amalgams, composites, crowns, etc.			Appointment [Appointment Date:		
☐ Preventive Care — sealants, fluoride treatment, prophylaxis			Appointment [Appointment Date:		
Pediatric Dentist Referral Recommended			Treatment Co	mpletion Date:		
Office Address:					Office Phone:	
Signature of Dentist:			License #:		Date:	

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

IOCI 25-1275 IOCI