



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 1st 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 of Exam _____

Address _____
Street City ZIP Code

Telephone _____





FORMULARIO COMPROBANTE DEL EXAMEN DENTAL ESCOLAR

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

Nombre del Estudiante:	Apellido	Nombre	Inicial	Fecha de Nacimiento: / / (Mes/Día/Año)
Dirección:	Calle	Ciudad	Código Postal	Número de Teléfono:
Nombre de la Escuela:	Grado:		Sexo: <input type="checkbox"/> Masculino <input type="checkbox"/> Femenino	
Nombre del padre/madre o encargado:		Dirección del padre/madre o encargado:		

To be completed by dentist: (Para ser completado por el dentista:)

Oral Health Status (check all that apply)

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Please note _____

Signature of Dentist _____

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