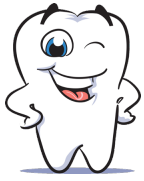
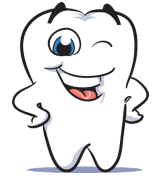


Attached is the dental exam form to be completed by a professional then returned to school.



# Dental Exams



\*DUE DATE: MAY 15, 2022\*

To: All Parent(s)/Guardian(s) of Kindergarten, Second and Sixth Grade Students

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➔ All Illinois children in grades kindergarten, second and sixth are required to have an oral health examination.

- The examination must be performed by a licensed dentist.
- Each child must present proof of an examination by a dentist prior to May 15 of the school year (s)he enters into one of the grades listed above.
- School dental examinations must have been completed within 18 months of the May 15 deadline.
- If a child's parent fails to present proof of a dental examination by May 15 of the current school year, the school may hold the child's report card until:
  - Proof of dental examination is presented within the specified time frame OR;
  - Proof that the dental examination will take place within 60 days after May 15 of the current school year is presented.
- Parent(s)/Guardian(s) who object to the dental examination on religious grounds must present to the appropriate school authority a signed detailed statement of objection.

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## 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):**

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)
Address:	Street	City		ZIP Code
Name of School:	ZIP Code		Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or Guardian:	Last Name		First Name	
Student's Race/Ethnicity:				
<input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Unknown <input type="checkbox"/> 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 (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      **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include 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 Completion Date: \_\_\_\_\_

Additional comments: \_\_\_\_\_

Signature of Dentist \_\_\_\_\_ License #: \_\_\_\_\_ Date: \_\_\_\_\_

