Dental Health Certificate - Optional

Parent/Guardian: Please complete Section 1 and take the form to your dentist/dental hygienist for an assessment. Request your dentist/dental hygienist to fill out Section 2. Return the completed form to your child's teacher as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: Male Female

Will this be your child's first visit to a dentist? Yes No

School: Name

Grade

Section 2. To be completed by the Dentist/Dental Hygienist

I. Oral Health Status (check all that apply)

Yes No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated?

[A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

Yes No **Untreated Caries –** Does this child have an open cavity?

[At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits 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 **Dental Sealants Present**

Yes No **Soft Tissue Pathology**

Yes No **Malocclusion**

II. Treatment Needs (check all that apply)

No need for Treatment

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, mouthguard etc.

Other – periodontal, orthodontic treatments

Please note _____

The Dental Health condition of _____ **on** _____ **(date of exam) Check one: Yes,**

☐**The student listed above *is* in fit condition of dental health to permit him/her attendance at the public schools. No, The**

☐**student listed above *is not* in fit condition of dental health to permit him/her attendance at the public schools.**

Dentist's Name and Address (Please Print or Stamp):

Dentist/Dental Hygienist Signature:

Date of Exam: / /

* The dental health condition of the student when the exam is made and the date of exam shall not be more than 12 months prior to the commencement of the school year in which the exam is requested.