

Dental Examination Form Information

- Holy Family School students entering **Kindergarten, Grade 2, and Grade 6** are required to provide a School Dental Examination Form.
- Examinations must be performed by a licensed dentist, who must sign and date the form.
- Kindergarten and Grade 2 students **must** present their dental form on Holy Family School Business Day in August prior to the start of school. The examination must have been completed within nine months prior to the start of the new school year.
- Sixth grade students only have until May 1, 2020, to present their form. Sixth grade examinations must have been completed within the 18 months prior to their May 1, 2020, deadline.
- The newest revised forms dated November 2015 must be used.
- Those unable to obtain the required dental examination may be able to present a signed and dated alternate Dental Examination Waiver Form if certain state guidelines are met: including having a child who is enrolled in the free and reduced lunch program but not covered by private or public dental insurance (Medicaid/All Kids); having a child enrolled in the free and reduced lunch program who is ineligible for public insurance (Medicaid/All Kids); having a child enrolled in Medicaid/All Kids, but the family is unable to find a dentist or dental clinic in the community able to see their child and will accept Medicaid/All Kids; or having a child who does not have any type of dental insurance and there are no low-cost dental clinics in the community that will see the child.



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: Holy Family School, Granite City, IL 62040			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 _____



**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 _____

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