

**Departamento de Salud Pública de Illinois**  
**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)**

- 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 1<sup>st</sup> 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 \_\_\_\_\_

Address \_\_\_\_\_  
Street City ZIP Code

Telephone \_\_\_\_\_