

CERTIFICATE OF DENTAL SCREENING

This certificate is not valid unless all fields are complete.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YY):
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Screening Information (health care provider must complete this section)

Date of Dental Screening: _____

Treatment Needs (check **ONE** only based on screening results, prior to treatment services provided):

- No Obvious Problems** – the child's hard and soft tissues appear to be visually health and there is no apparent reason for the child to be seen before the next routine dental checkup.
- Requires Dental Care** – tooth decay¹ or a white spot lesion² is suspected in one or more teeth, or gum infection³ is suspected.
- Requires Urgent Dental Care** – obvious tooth decay¹ is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

¹ Tooth Decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.

² White spot lesion: A demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gumline. A white spot lesion is considered an early indicator of tooth decay, especially in primary (baby) teeth.

³ Gum infection: Gum (gingival) tissue is red, bleeding, or swollen.

Screening Provider (check **ONE** only): (Ninth grade screening must be provided by DDS/DMD or RDH.)

DDS/DMD RDH MD/DO PA RN/ARNP

Provider Name: (please print) _____ Phone: _____

Provider Business Address: _____

Signature and Credentials of Provider or Recorder*: _____ Date: _____

*Recorder: An authorized provider (DDS/DMD, RDH MD/DO, PA, or RN/ARNP) may transfer information on this form from another health department. The other health document should be attached to this form.

A screening does not replace an exam by a dentist.
Children should have a complete examination by a dentist at least once a year.
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