DENTAL EXAMINATION RECORD

INFORMATION N THIS FORM MAY BE SHARED WITH APPROPRIATE PERSONNEL FOR HEALTH AND EDUCATIONAL PURPOSES

TO BE COMPLETED BY THE PARENT (THIS PORTION ONLY)

PUPIL'S NAME LAST FIRST MIDDLE | BIRTHDATE MONTH DAY YEAR

ADDRESS: STREET CITY ZIP CODE | TELEPHONE

NAME OF SCHOOL: | GRADE LEVEL | SEX ☐ Male ☐ Female

PARENT OR GUARDIAN: | ADDRESS

1. IS YOUR CHILD RECEIVING FLUORIDE TREATMENTS IN SCHOOL? ☐ YES ☐ NO COMMENT _____

2. DOES YOUR CHILD HAVE ANY MEDICAL PROBLEM THAT MAY COMPLICATE DENTAL TREATMENT? (i.e. ALLERGIES, DIABETES, RESPIRATORY DIFFICULTY, HISTORY OF RHUEMATIC FEVER, ETC.) ☐ YES ☐ NO EXPLAIN _____

TO BE COMPLETED BY DENTIST:

CURRENT DENTAL STATUS OF PATIENT:

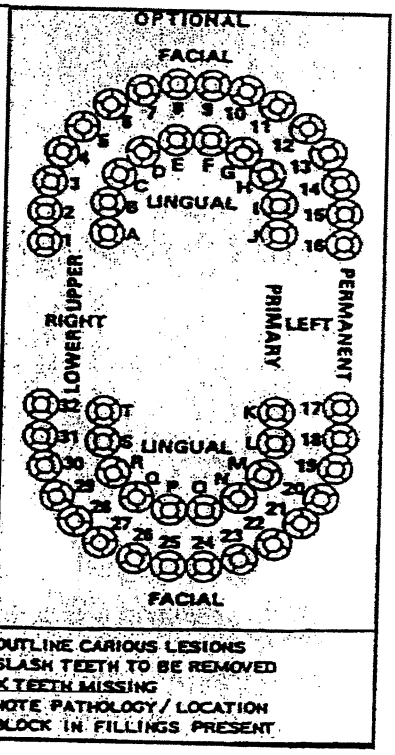
☐ URGENT—(ABCESS FORMATION, NERVE EXPOSURE, ADVANCED DISEASE STATE INCLUDING HANDICAPPED INDIVIDUALS)

☐ ROUTINE DENTAL CARE NEEDED—(ALLOYS, COMPOSITES, STAINLESS STEEL CROWNS, ETC.)

☐ PREVENTENTVE DENTISTRY ONLY NEEDED—(PROPHYLAXIS, FLOURIDE TREATMENT, SEALANTS, ETC.)

☐ NO TREATMENT REQUIRED

☐ OTHER



PATHOLOGY PRESENT

HARD TISSUE ☐ YES ☐ NO DESCRIBE _____

SOFT TISSUE ☐ YES ☐ NO DESCRIBE _____

MALOCCLUSION ☐ YES ☐ NO TYPE _____

ORTHODONTIC REFERRAL RECOMMENDED ☐ YES ☐ NO

Name of Dental Facility _____

SIGNATURE OF DENTIST: _____ DATE: _____

ADDRESS: _____ TELEPHONE
STREET CITY ZIP CODE

PLEASE PRINT OR STAMP

IDPH-DEA.001 10/80 IL 482-0384

Updated 5/18/15 CCT

Vision Exam Report Form:

Name of Facility:	
Address:	City/State

Name: _____ Date of Birth: _____

Visual Acuity: Right eye with glasses _____ Right eye without glasses _____
Left eye with glasses _____ Left eye without glasses _____

Alignment:

- Straight _____ Tropia _____ Phoria _____

Diagnosis: _____ Prescription _____

__ *No Further evaluation is necessary at this time*
__ *Follow-up is recommended in* _____ *month(s)* *year(s)*

The following educational considerations are recommended:

- Preferential seating in classroom: Where:_____
- Glasses to be worn at all time
- Glasses to be worn part time, primarily for: reading___ Distance: ___
- Full participation in Physical Education classes
- Restricted Physical Education: Restrictions

_____
_____

Other _____

Signature: _____ Name (Print): _____

Date of Exam _____