



ST. TERESA CATHOLIC SCHOOL

1108 LEBANON AVENUE
BELLEVILLE, IL 62221

Dear Parents/Guardians:

Students entering **Kindergarten, Second, and Sixth Grades** are required by the State of Illinois to have a dental form submitted to school. The student must have had a dental exam within eighteen months prior to the deadline date. It will be required to be on file by **May 15th of the current school year.**

The forms are being sent home now so that you may schedule these appointments.

If you have any questions or concerns, please contact me at the school office Monday thru Friday during school hours at 235-4066.

Sincerely,

Janine L. Gosebrink, RN, BSN
Nurse

Sandy Jouglard
Interim Principal

Illinois Department of Public Health 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:	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 _____

Address _____
Street City ZIP Code

Telephone _____