H. Serv. 102 — (Rev. 2-81)
Com. No. 292

CHICAGO PUBLIC SCHOOLS
Bureau of Medical and School Health Services

DENTAL EXAMINATION RECORD

STUDENT NUMBER

IDPA NUMBER

LAST NAME	FIRST	MIDDLE	BIRTH DATE	PLACE OF BIRTH - CITY AND STATE
ADDRESS			SCHOOL	GRADE
PARENT OR GUARDIAN			TELEPHONE	

TO THE PARENT:
In order to comply with the School Code of the State of Illinois, please make an early dental appointment for the above-named child. Take this form with you, have it completed by the dentist and return it to the teacher.

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 Rheumatic Fever, Etc.)* ☐ Yes ☐ No Explain_____

TO BE COMPLETED BY DENTIST:

CURRENT DENTAL STATUS OF PATIENT:

- ☐ URGENT — *(Abscess Formation, Nerve Exposure, Advanced Disease State Including Handicapped Individuals)*
- ☐ ROUTINE DENTAL CARE NEEDED — *(Alloys, Composites, Stainless Steel Crowns, Etc.)*
- ☐ PREVENTIVE DENTISTRY ONLY NEEDED — *(Prophylaxis, Fluoride Treatment, Sealants, Etc.)*
- ☐ NO TREATMENT REQUIRED
- ☐ OTHER_____

PATHOLOGY PRESENT

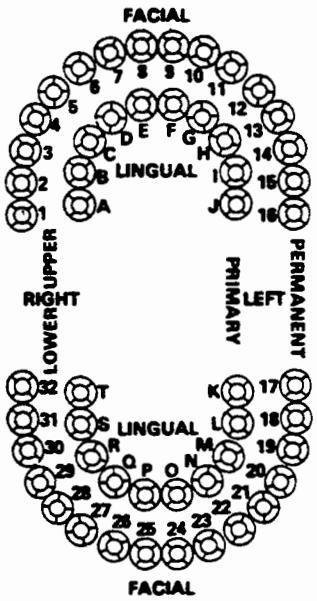
HARD TISSUE ☐ Yes ☐ No Describe _____

SOFT TISSUE ☐ Yes ☐ No Describe _____

MALOCCLUSION ☐ Yes ☐ No Type_____

ORTHODONTIC REFERRAL RECOMMENDED ☐ Yes ☐ No

OPTIONAL



OUTLINE CARIOUS LESIONS
SLASH TEETH TO BE REMOVED
X TEETH MISSING
NOTE PATHOLOGY / LOCATION
BLOCK IN FILLINGS PRESENT

Signature of Dentist _____ Date _____

TELEPHONE

Address_____
STREET CITY ZIP CODE

This form is to be returned to the teacher. It becomes a part of the permanent health record.