



Dear Incoming Kindergarten Parents/Guardians,

All students entering Kindergarten must have a NEW Physical Exam (PE) and Immunization record before the start of the 2025-2026 school year.

****PLEASE NOTE:**** Healthcare providers often overlook or fail to complete all required sections of the health form. Please ensure you check the form against this checklist before leaving the provider's office. It is the parent's responsibility to verify that all sections are completed in full.

Physical Exam and Immunization Requirement Checklist

- ☐ Physical Exam (PE) must be recorded on the State of Illinois Certificate of Child Health Examination form within one year prior to the first day of school
- ☐ The parent/guardian portion (ie. Health History) must be completed and signed by parent/guardian
- ☐ ALL BOXES must be completed and initialed by the healthcare provider at the time of the examination. This includes these boxes:

Diabetes Screen	Lead Risk Questionnaire	TB Skin or Blood Test
System Review/BMI	Emergency Action Plan	PE/Interscholastic

- ☐ All required immunizations must be documented on, or attached to this form.

Students not in compliance with this regulation by 3 pm Tuesday, October 14, 2025, will be excluded from attendance beginning Wednesday, October 15, 2025.

Additional Requirements

- ☐ Vision Examination - Students entering kindergarten must provide a completed and signed STATE OF ILLINOIS VISION EXAMINATION FORM. The vision examination must be performed by a physician or licensed optometrist within 12 months of the first day of school.
- ☐ Dental Examination - Students entering kindergarten must provide a completed and signed Illinois PROOF OF SCHOOL DENTAL EXAMINATION FORM by May 15, 2026. The exam must have been completed within 18 months prior to this date (any date after November 15, 2024).

All forms including the Certificate of Child Health and the Dental Exam form can be found on our website at <https://www.d105.net/domain/28> If you need additional printed copies, they are available at each school.

Thank you,
District 105 Health Office Team



Distrito Escolar 105

Servicio de salud

Campo • hodgkins • el granero

Intermedia Gurrie (708)-482-2720

Séptima Avenida (708)-482-2730

Ideal (708)-482-2750

Hodgkins (708)-482-2740

Avenida Primavera (708)-482-2710

Estimados padres/tutores entrantes al jardín de infantes:

Todos los estudiantes que ingresan al jardín de infantes deben tener un NUEVO examen físico (PE) y un registro de vacunas antes del inicio del año escolar 2025-2026.

****TENGA EN CUENTA:**** Los proveedores de atención médica a menudo pasan por alto o no completan todas las secciones requeridas del formulario de salud. Asegúrese de comparar el formulario con esta lista de verificación antes de salir del consultorio del proveedor. Es responsabilidad de los padres verificar que todas las secciones estén completas en su totalidad.

Lista de verificación de requisitos de vacunación y examen físico

- ☐ El examen físico (PE) debe registrarse en el formulario del Certificado de examen de salud infantil del estado de Illinois dentro de un año antes del primer día de clases.
- ☐ La parte del padre/tutor (es decir, el historial médico) debe ser completada y firmada por el padre/tutor
- ☐ TODAS LAS CASILLAS deben ser completadas y rubricadas por el proveedor de atención médica en el momento del examen. Esto incluye estas cajas:

Prueba de diabetes	Cuestionario de riesgo de plomo	Prueba de tuberculosis en piel o sangre
Revisión del sistema/IMC	Plan de acción de emergencia	Educación Física/Interescolar

- ☐ Todas las vacunas requeridas deben documentarse o adjuntarse a este formulario.

Los estudiantes que no cumplan con este reglamento antes de las 3 p. m. del martes 14 de octubre de 2025 serán excluidos de la asistencia a partir del miércoles 15 de octubre de 2025.

Requisitos adicionales

- ☐ Examen de la vista: los estudiantes que ingresan al jardín de infantes deben proporcionar un FORMULARIO DE EXAMEN DE LA VISTA DEL ESTADO DE ILLINOIS completo y firmado. El examen de la vista debe ser realizado por un médico u optometrista autorizado dentro de los 12 meses posteriores al primer día de clases.
- ☐ Examen dental: los estudiantes que ingresan al jardín de infantes deben proporcionar un FORMULARIO DE EXAMEN DENTAL DE PRUEBA DE ESCUELA de Illinois completo y firmado antes del 15 de mayo de 2026. El examen debe haberse completado dentro de los 18 meses anteriores a esta fecha (cualquier fecha posterior al 15 de noviembre de 2024).

Todos los formularios, incluido el Certificado de salud infantil y el formulario de examen dental, se pueden encontrar en nuestro sitio web en <https://www.d105.net/dominio/28> Si necesita copias impresas adicionales, están disponibles en cada escuela.



Certificate of Child Health Examination

Student's Name			Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#						
Last First Middle												
Street Address City ZIP Code			Parent/Guardian			Telephone (home/work)						
HEALTH HISTORY: MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER												
ALLERGIES (Food, drug, insect, other)		<input type="checkbox"/> Yes <input type="checkbox"/> No	List:		MEDICATION (Prescribed or taken on a regular basis)		<input type="checkbox"/> Yes <input type="checkbox"/> No	List:				
Diagnosis of Asthma?		<input type="checkbox"/> Yes <input type="checkbox"/> No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Child wakes during night coughing?		<input type="checkbox"/> Yes <input type="checkbox"/> No			Hospitalization? When? What for?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Birth Defects?		<input type="checkbox"/> Yes <input type="checkbox"/> No			Surgery? (List all) When? What for?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Developmental delay?		<input type="checkbox"/> Yes <input type="checkbox"/> No			Serious injury or illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.		<input type="checkbox"/> Yes <input type="checkbox"/> No			TB skin test positive (past/present)?		<input type="checkbox"/> Yes* <input type="checkbox"/> No	*if yes, refer to local health department				
Diabetes?		<input type="checkbox"/> Yes <input type="checkbox"/> No			TB disease (past or present)?		<input type="checkbox"/> Yes* <input type="checkbox"/> No					
Head injury/Concussion/Passed out?		<input type="checkbox"/> Yes <input type="checkbox"/> No			Tobacco use (type, frequency)?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Seizures? What are they like?		<input type="checkbox"/> Yes <input type="checkbox"/> No			Alcohol/Drug use?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Heart problem/Shortness of breath?		<input type="checkbox"/> Yes <input type="checkbox"/> No			Family history of sudden death before age 50? (Cause?)		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Heart murmur/High blood pressure?		<input type="checkbox"/> Yes <input type="checkbox"/> No										
Dizziness or chest pain with exercise?		<input type="checkbox"/> Yes <input type="checkbox"/> No										
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts Last exam by eye doctor _____					<input type="checkbox"/> Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other							
Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) _____					Additional Information:							
Ear/Hearing problems? <input type="checkbox"/> Yes <input type="checkbox"/> No					Information may be shared with appropriate personnel for health and educational purposes.							
Bone/Joint problem/injury/scoliosis? <input type="checkbox"/> Yes <input type="checkbox"/> No					Parent/Guardian Signatures: _____ Date: _____							
IMMUNIZATIONS: To be completed by health care provider. The mo/day/yr for every dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.												
REQUIRED Vaccine/Dose	DOSE 1 MO DA YR		DOSE 2 MO DA YR		DOSE 3 MO DA YR		DOSE 4 MO DA YR		DOSE 5 MO DA YR		DOSE 6 MO DA YR	
DTP or DTaP												
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV	
Hib Haemophiles Influenza Type B												
Pneumococcal Conjugate												
Hepatitis B												
MMR Measles, Mumps, Rubella												
Varicella (Chickenpox)												
Meningococcal Conjugate												
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose												
Hepatitis A												
HPV												
Influenza												
Other: Specify Immunization Administered/Dates												
Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.												
Signature _____ Title _____ Date _____												

Student's Name			Birth Date (Mo/Day/Yr)	Sex	School	Grade Level/ID#
Last	First	Middle				
Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and <i>Maintained</i> by the School Authority.						
ALTERNATIVE PROOF OF IMMUNITY						
1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.						
*MEASLES (Rubeola) (MO/DA/YR) **MUMPS (MO/DA/YR) HEPATITIS B (MO/DA/YR) VARICELLA (MO/DA/YR)						
2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.						
Date of Disease Signature Title						
3. Laboratory Evidence of Immunity (check one) <input type="checkbox"/> Measles* <input type="checkbox"/> Mumps** <input type="checkbox"/> Rubella <input type="checkbox"/> Varicella Attach copy of lab result.						
*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence. **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.						
Physician Statements of Immunity MUST be submitted to IDPH for review.						
Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature:						
PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA						
HEAD CIRCUMFERENCE if < 2-3 years old HEIGHT WEIGHT BMI BMI PERCENTILE B/P						
DIABETES SCREENING: (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex <input type="checkbox"/> Yes <input type="checkbox"/> No And any two of the following: Family History <input type="checkbox"/> Yes <input type="checkbox"/> No						
Ethnic Minority <input type="checkbox"/> Yes <input type="checkbox"/> No Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) <input type="checkbox"/> Yes <input type="checkbox"/> No At Risk <input type="checkbox"/> Yes <input type="checkbox"/> No						
LEAD RISK QUESTIONNAIRE: Required for children aged 6 months through 6 years enrolled in licensed or public-school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high-risk zip code.)						
Questionnaire Administered? <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Test Indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Test Date Result						
TB SKIN OR BLOOD TEST: Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm .						
<input type="checkbox"/> No test needed <input type="checkbox"/> Test performed Skin Test: Date Read Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative mm						
Blood Test: Date Reported Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Value						
LAB TESTS (Recommended)	Date	Results	SCREENINGS	Date	Results	
Hemoglobin or Hematocrit			Developmental Screening		<input type="checkbox"/> Completed <input type="checkbox"/> N/A	
Urinalysis			Social and Emotional Screening		<input type="checkbox"/> Completed <input type="checkbox"/> N/A	
Sickle Cell (when indicated)			Other:			

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin	<input type="checkbox"/>		Endocrine	<input type="checkbox"/>	
Ears	<input type="checkbox"/>	Screening Result:	Gastrointestinal	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	Screening Result:	Genito-Urinary	<input type="checkbox"/>	LMP:
Nose	<input type="checkbox"/>		Neurological	<input type="checkbox"/>	
Throat	<input type="checkbox"/>		Musculoskeletal	<input type="checkbox"/>	
Mouth/Dental	<input type="checkbox"/>		Spinal Exam	<input type="checkbox"/>	
Cardiovascular/HTN	<input type="checkbox"/>		Nutritional Status	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/> Diagnosis of Asthma	Mental Health	<input type="checkbox"/>	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g., Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g., inhaled corticosteroid)			Other	<input type="checkbox"/>	
NEEDS/MODIFICATIONS required in the school setting			DIETARY Needs/Restrictions		
SPECIAL INSTRUCTIONS/DEVICES (e.g., safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup)					
MENTAL HEALTH/OTHER Is there anything else the school should know about this student?					
If you would like to discuss this student's health with school or school health personnel, check title: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal					
EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:					
On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)					
PHYSICAL EDUCATION <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified INTERSCHOLASTIC SPORTS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified					
Print Name <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> APN <input type="checkbox"/> PA Signature Date					
Address Phone					



State of Illinois

Certificate of Child Health Examination

Student's Name		Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#
Last	First	Middle			
Street Address		City	ZIP Code	Parent/Guardian	Telephone (home/work)
HISTORIAL DE SALUD: DEBE SER COMPLETADO Y FIRMADO POR EL PADRE/TUTOR Y VERIFICADO POR EL PROVEEDOR DE ATENCIÓN MÉDICA.					
ALERGIAS (Alimentos, drogas, insectos, otro)	<input type="checkbox"/> Sí <input type="checkbox"/> No	Anote todas las alergias:	MEDICAMENTOS (Recetados o tomados con regularidad)	<input type="checkbox"/> Sí <input type="checkbox"/> No	Anote todos los medicamentos:
¿Tiene diagnóstico de asma?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Tiene pérdida de funciones en uno de los órganos? (Ojos/Oídos/Riñones/Testículos)	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Despierta el niño tosliendo en la noche?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Ha sido hospitalizado?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Tiene defectos de nacimiento?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Cuándo? ¿Para qué?		
¿Tiene retrasos del desarrollo?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Ha tenido alguna cirugía? (andélas todas)	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro. Explique.	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Cuándo? ¿Para qué?		
¿Tiene diabetes?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Ha tenido heridas graves o enfermedades?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Tiene heridas en la cabeza/golpe/desmayo?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Prueba positiva de TB (Pasado o Presente)?	<input type="checkbox"/> Sí* <input type="checkbox"/> No	*Si contestó sí, refiera al departamento de salud local
¿Tiene convulsiones? Cómo se manifiestan?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Enfermedad de TB (Pasado o Presente)?	<input type="checkbox"/> Sí* <input type="checkbox"/> No	
¿Tiene problemas cardíacos/Dificultad para respirar?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Uso tabaco (tipo, frecuencia)?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Tiene soplo en el corazón/presión arterial alta?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Toma alcohol/drogas?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Tiene mareos o dolor de pecho al hacer ejercicios?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Historial de familiares de muerte repentina antes de los 50 años? ¿Causa?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Problemas con los ojos/visión?	<input type="checkbox"/> Lentes <input type="checkbox"/> Lentes de Contacto	Último examen		<input type="checkbox"/> Dental <input type="checkbox"/> Frenos <input type="checkbox"/> Puente <input type="checkbox"/> Placas <input type="checkbox"/> Otro	
¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee)			Información Adicional:		
¿Tiene problemas de los oídos/no oye bien?	<input type="checkbox"/> Sí <input type="checkbox"/> No		La información en este formulario se pueda compartir con el personal apropiado para propósitos de salud y educación.		
¿Tiene problemas de los huesos/articulaciones/heridas/escoliosis?	<input type="checkbox"/> Sí <input type="checkbox"/> No		Firma del Padre/Tutor: _____ Fecha: _____		



State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)
Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)
Parent or Guardian _____
(Last) (First)
Phone _____
(Area Code)
Address _____
(Number) (Street) (City) (ZIP Code)
County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____
Ocular history: ☐ Normal or Positive for _____
Medical history: ☐ Normal or Positive for _____
Drug allergies: ☐ NKDA or Allergic to _____
Other information _____

Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ☐ Yes ☐ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other _____



State of Illinois Eye Examination Report

Recommendations

1. Corrective lenses: ☐ No ☐ Yes, glasses or contacts should be worn for:
☐ Constant wear ☐ Near vision ☐ Far vision
☐ May be removed for physical education

2. Preferential seating recommended: ☐ No ☐ Yes

Comments _____

3. Recommend re-examination: ☐ 3 months ☐ 6 months ☐ 12 months
☐ Other _____

4. _____

5. _____

Print name _____
Optometrist or physician (such as an ophthalmologist)
who provided the eye examination ☐ MD ☐ OD ☐ DO

License Number _____

Address _____

Phone _____

Signature _____

Date _____

Consent of Parent or Guardian

I agree to release the above information on my child
or ward to appropriate school or health authorities.

(Parent or Guardian's Signature)

(Date)

(Source: Amended at 32 Ill. Reg. _____, effective _____)



PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)
Address:	Street	City	ZIP Code	
Name of School:	ZIP Code	Grade Level:	Gender: <input type="radio"/> Male <input type="radio"/> Female	
Parent or Guardian:	Last Name	First Name		
Student's Race/Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____				

To be completed by dentist:

Date of Most Recent Examination: _____ (Check all services provided at this examination date)
☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

☐ 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 **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

☐ **Restorative Care** — amalgams, composites, crowns, etc.

Appointment Date: _____

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

Appointment Date: _____

☐ **Pediatric Dentist Referral Recommended**

Treatment Completion Date: _____

Additional comments: _____

Signature of Dentist _____ License #: _____ Date: _____

