Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

Ossining UFSD
Health Services

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp) Dentist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits 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 **Dental Sealants Present**

Other problems (Specify):_____

III. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

Certificado de Salud Dental

Padre/Tutor: La ley del estado de Nueva York (Capitulo 281) autoriza a las escuelas que estipulen los exámenes dentales de niños en los grados siguientes: cuando primero entran al sistema escolar, jardín de infancia, segundo, cuarto, séptimo y décimo. Su niño puede tomar un examen dental durante este año escolar para determinar su elegibilidad para asistir a la escuela. Por favor llene la sección una de este formulario y entrégueselo al dentista para su evaluación. Si su niño(a) tuvo un examen antes que comenzará en la escuela, pida que su dentista llene la sección 2. Devuelve el formulario completado lo mas antes posible a la enfermera o el director médico de la escuela.

Sección 1. Para ser completado por el padre o tutor (letra de molde por favor)

Nombre del niño(a) **apellido** **primer** **segundo nombre**

Fecha de nacimiento **mes** / **día** / **año** /

Sexo: ☐ **masculino** ☐ **femenino**

¿Será esta la primera visita de su niño a un dentista? ☐ **sí** ☐ **no**

Escuela: Grado:

¿Usted ha notado cualquier problema con la boca de su niño que interfiere con su habilidad de masticar, hablar o concentración en las actividades de la esculea?

☐ sí ☐ no

El dentista debe llenar la parte al otro lado de esta página.