



DENTAL HEALTH CERTIFICATE - OPTIONAL

VESTAL NEW YORK 13850

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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 registered dentist or registered hygienist for an assessment. If your child had a dental check-up before he/she started school, ask your dentist/dental hygienist 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)			
Last	First	Middle	
Child's Name: _____			
Birth Date: / / /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first oral health assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Month	Day	Year	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.			
I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.			
Parent's Signature _____			Date _____
Section 2. To be completed by the Dentist/Dental Hygienist			
I. The dental health condition of _____ on _____ (date of assessment). The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:			
<input type="checkbox"/> Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.			
<input type="checkbox"/> 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/Dental Hygienist's name and address (please print or stamp)		Dentist's/Dental Hygienist'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).			
<input type="checkbox"/> Yes <input type="checkbox"/> 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].			
<input type="checkbox"/> Yes <input type="checkbox"/> No Untreated Caries - Does this child have an open cavity? [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 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].			
<input type="checkbox"/> Yes <input type="checkbox"/> No Dental Sealants Present			
Other problems (Specify): _____			
III. Treatment Needs (check all that apply)			
<input type="checkbox"/> No obvious problem. Routine dental care is recommended. Visit your dentist regularly.			
<input type="checkbox"/> May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.			
<input type="checkbox"/> Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.			

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