Iowa Department of Public Health
CERTIFICATE OF DENTAL SCREENING

This certificate is not valid unless all fields are complete.
RETURN COMPLETED FORM TO CHILD’S SCHOOL.

Student Information (please print)

<table>
<thead>
<tr>
<th>Student Last Name:</th>
<th>Student First Name:</th>
<th>Birth Date (M/D/YYYY):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Parent or Guardian Name:</th>
<th>Telephone (home or mobile):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address:</th>
<th>City:</th>
<th>County:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Elementary or High School:</th>
<th>Grade Level:</th>
<th>Gender:</th>
</tr>
</thead>
</table>

Screening Information (health care provider must complete this section)

Date of Dental Screening: ________________

Treatment Needs (check ONE only based on screening results, prior to treatment services provided):

- [ ] No Obvious Problems – the child’s hard and soft tissues appear to be visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.
- [ ] Requires Dental Care – tooth decay¹ or a white spot lesion² is suspected in one or more teeth, or gum infection³ is suspected.
- [ ] Requires Urgent Dental Care – obvious tooth decay¹ is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

¹ Tooth decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.
² White spot lesion: A demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gumline. A white spot lesion is considered an early indicator of tooth decay, especially in primary (baby) teeth.
³ Gum infection: Gum (gingival) tissue is red, bleeding, or swollen.

Screening Provider (check ONE only):

- [ ] DDS/DMD
- [ ] RDH
- [ ] MD/DO
- [ ] PA
- [ ] RN/ARNP

High school screen must be provided by DDS/DMD or RDH

Provider Name: (please print) ____________________________ Provider Business Phone: ________________

Provider Business Address: ________________________________

Signature and Credentials of Provider or Recorder*: ____________________________ Date: ________________

*Recorder: An authorized provider (DDS/DMD, RDH, MD/DO, PA, or RN/ARNP) may transfer information onto this form from another health document. The other health document should be attached to this form.

A screening does not replace an exam by a dentist.
Children should have a complete examination by a dentist at least once a year.

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Iowa Department of Public Health • Oral Health Bureau
515-281-3733 • 866-528-4020 • www.idph.state.ia.us/hpcdp/oral_health.asp

A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.

7/14/2010