

# 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.

## Parent or Guardian Section (please print)

Student Last Name:	Student First Nam	e:	Birth Date (M/D/YYYY):
Parent or Guardian Name:		Telephone (	(home): mobile):
Street Address:	City:		County:
Name of Elementary or High School:		Grade Level:	Gender:

## Health Care Provider Section (provider to complete all fields)

Date of Dental Screening:				
Treatmen	Treatment Needs (check ONE only based on screening results, prior to treatment services provided): <ul> <li>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.</li> </ul>			
	Requires Dental Care – tooth decay* or a white spot lesion** is suspected in one or more teeth.			
	<b>Requires Urgent Dental Care</b> – obvious tooth decay* is present in one or more teeth, the child is experiencing pain, or there is evidence of infection or injury.			
<ul> <li>*Tooth decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.</li> <li>**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.</li> </ul>				
Provider Type (check ONE only):				
Provider Name: (please print)		Provider Signature:		
Business	Address:			
Business	Phone:			

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 • <u>www.idph.state.ia.us/hpcdp/oral\_health.asp</u>

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