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## STATE DENTAL REQUIREMENTS KINDERGARTEN, SECOND GRADE, and SIXTH GRADE

### Dental Exam Information:

Illinois State Law **REQUIRES** all children entering an Illinois school present written proof of a dental examination performed and signed by a licensed dentist. The dental exam is required by March 1<sup>st</sup> 2011 of the Kindergarten, 2<sup>nd</sup> and 6<sup>th</sup> grade school year. It can be as early as November 15, 2010. Attached is the Illinois State mandated dental form, no other forms will be accepted.

We ask that the completed dental record be returned to the school office as soon as possible, and no later than March 1<sup>st</sup> 2011.

If you have any questions concerning the State Dental Requirements, please contact Mrs. Armando R.N. at 847-885-7702.

Sincerely,

Vito C. De Frisco  
Principal

Mrs. Marcia Larson  
Assistant Principal

# Illinois Department of Public Health PROOF OF SCHOOL DENTAL EXAMINATION FORM



**To be completed by the parent (please print):**

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)
				/ /
Address:	Street	City	ZIP Code	Telephone:
Name of School:	Grade Level:		Gender:	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent or Guardian:	Address (of parent/guardian):			

**To be completed by dentist:**

**Oral Health Status (check all that apply)**

Yes     No    **Dental Sealants Present**

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 1<sup>st</sup> 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    **Soft Tissue Pathology**

Yes     No    **Malocclusion**

**Treatment Needs (check all that apply)**

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

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

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

**Other** — periodontal, orthodontic

Please note \_\_\_\_\_

Signature of Dentist \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_  
Street
City
ZIP Code

Telephone \_\_\_\_\_