TV 105 (10/2020)

TechValley HIGH SCHOOL

Dental Health Certificate

Parent/Guardian: New York State Law requires school districts to request Dental Certificates for students when they enter school and in grades K, 1, 3, 5, 7, 9 and 11. Please complete Section 1 of this form and have your child's dental care provider complete Section 2. The dental assessment may be completed during or 12 months prior to the school year in which it is required. Return the completed form to the School Nurse by *January 1st*.

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:		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

Section 2. To be completed by the Dental Care Provider

Child's Name: _____ Date of Exam: _____

The dental exam may be completed during or 12 months prior to the school year in which it is required.

Check one:

[] Yes - The student listed above is in fit condition of dental health to permit his/her attendance at school.

[] No - The student listed above is not in fit condition of dental health to permit his/her attendance at school.

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 school does not preclude the student from attending school.

Dental Care Provider's Name & Address: _____

_____

_____

Stamp:

Dental Care Provider's Signature: _____ Phone Number: _____

Oral Health Status (check all that apply).

Caries Experience/Restoration History: ☐ **Yes** ☐ **No**
Has the child ever had a cavity (treated or untreated) or extraction?

Untreated Caries: ☐ **Yes** ☐ **No**
Does this child have an open cavity?

Dental Sealants Present ☐ **Yes** ☐ **No**

Fluoride Supplements: ☐ **Yes** ☐ **No**

Other Observations (Specify): _____

_____

Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended.
☐ Immediate dental care is required.
☐ Requires an appointment with a dentist for further care.
☐ Date of Appointment: _____