

CERTIFICATE OF DENTAL SCREENING

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

Student Information (pl	ease print)		
Student Last Name:	Student First Name: Birth Date (M/D/YY):		
Screening Information	(health care provider r	must complete t	his section)
Date of Dental Screening	g:		
Treatment Needs (check	ONE only based on s	creening results	s, prior to treatment services provided):
No Obvious Prob apparent reason for	lems – the child's hard the child to be seen b	d and soft tissue efore the next r	es appear to be visually health and there is no coutine dental checkup.
Requires Dental C gum infection ³ is sus		r a white spot le	esion ² is suspected in one or more teeth, or
Requires Urgent I evidence of injury or	Dental Care – obvious severe infection, or the	us tooth decay! he child is expe	is present in one or more teeth, there is riencing pain.
² White spot lesion: A demir	neralized area of a tooth, is considered an early ir	, usually appearing adicator of tooth	c coloration, or a retained root. g as a chalky, white spot or white line near the decay, especially in primary (baby) teeth.
Screening Provider (check	(ONE only): (Ninth gra	ade screening must	be provided by DDS/DMD or RDH.)
□ DDS/DMD □ RDH	□ MD/DO □ PA	□ RN/ARNP	
Provider Name: (please print)			Phone:
Provider Business Address:			
Signature and Credentials of Provider or Recorder*:			Date:
			NP) may transfer information on this form from another

A screening does not replace an exam by a dentist. Children should have a complete examination by a dentist at least once a year. RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Iowa Department of Health and Human Services • Bureau of Oral and Health Delivery Systems 1-866-528-4020 • https://idph.iowa.gov/ohds A designee of the local board of health or lowa Department of Health and Human Services may review this certificate for survey purposes.