

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH
SCHOOL DENTAL HEALTH RECORD

Complete the following section before the examination/screen:

SCHOOL DISTRICT/CHARTER SCHOOL										COUNTY				DATE OF BIRTH			
STUDENT: LAST FIRST MIDDLE										GRADE				SEX M <input type="checkbox"/> F <input type="checkbox"/>			
HOME ADDRESS										TELEPHONE NO.							

Record on Dental Chart: Deciduous teeth - **d** (Decayed), **e** (indicated for extraction), and **f** (filled)
Permanent teeth - **D** (Decayed), **M** (Missing), and **F** (Filled)

		TOOTH CHART																	
		RIGHT								LEFT									
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		
					A	B	C	D	E	F	G	H	I	J					
		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17		
		T	S	R	Q	P	O	N	M	L	K								
UPPER	Upper																	UPPER	
	Lower																	LOWER	
First Exam or Screen	Upper																	UPPER	
	Lower																	LOWER	
Second Exam or Screen	Upper																	UPPER	
	Lower																	LOWER	
Third Exam or Screen	Upper																	UPPER	
	Lower																	LOWER	
Fourth Exam or Screen	Upper																	UPPER	
	Lower																	LOWER	
Fifth Exam or Screen	Upper																	UPPER	
	Lower																	LOWER	

Untreated Decay: No Yes
Treated Decay: No Yes
Any Sealants on Permanent Molars: No Yes
Treatment Urgency: None Early Urgent

Date of Visit: _____

Name of Dental Provider _____ Signature _____

Address _____ Phone _____

STUDENT REFERRAL			
DATE	EXAMINED or SCREENED BY	REFERRED TO	REMARKS (if yes, provide details at bottom of page)
1ST EXAM or SCREEN			Yes <input type="checkbox"/> No <input type="checkbox"/>
2ND EXAM or SCREEN			Yes <input type="checkbox"/> No <input type="checkbox"/>
3RD EXAM or SCREEN			Yes <input type="checkbox"/> No <input type="checkbox"/>
4TH EXAM or SCREEN			Yes <input type="checkbox"/> No <input type="checkbox"/>
5TH EXAM or SCREEN			Yes <input type="checkbox"/> No <input type="checkbox"/>

DENTAL FINDINGS – Check Applicable Items

GRADE	DATE	EXAMINED or SCREENED BY	PROPHYLAXIS	SPECIAL PROJECTS (Specify)	FLUORIDE	NUTRITION COUNSELING	SEALANTS			TOTALS		TOOTH BRUSH INSTRUCTIONS	Oral Evaluation Passed/ Referred
					VARNISH		PREMOLARS	1 ST MOLARS	2 ND MOLARS	Def DMF	OHI Index		
K													
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
Other													

Remarks

DATE	
DATE	
DATE	
DATE	