



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.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent or Guardian Name:		Telephone (home or mobile):
Street Address:	City:	County:
Name of Elementary or High School:	Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

Screening Information (health care provider must complete this section)

Date of Dental Screening: _____

Treatment Needs (check ONE only based on screening results, prior to treatment services provided):

- 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.
- Requires Dental Care** – tooth decay¹ or a white spot lesion² is suspected in one or more teeth, or gum infection³ is suspected.
- Requires Urgent Dental Care** – obvious tooth decay¹ is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

¹ Tooth decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.
² 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.
³ Gum infection: Gum (gingival) tissue is red, bleeding, or swollen.

Screening Provider (check ONE only):

DDS/DMD RDH MD/DO PA RN/ARNP (High school screen must be provided by DDS/DMD or RDH)

Provider Name: (please print) _____ Provider Business Phone: _____

Provider Business Address: _____

Signature and Credentials of Provider or Recorder*: _____ Date: _____

*Recorder: An authorized provider (DDS/DMD, RDH, MD/DO, PA, or RN/ARNP) may transfer information onto this form from another health document. The other health document should be attached to this form.

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 • www.idph.state.ia.us/hpcdp/oral_health.asp

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

Dental Screening Requirement for School Enrollment

Iowa children enrolling into Kindergarten or 9th grade are required to have a dental screening.

$2+6=8$

Elementary

- Applies to Kindergarten students only (REVISED)
- Screening must occur no earlier than age 3 and no later than 4 months after enrollment (REVISED)
- Screenings can be performed by: dentists, dental hygienists, physicians, registered nurses, or physician assistants

High School

- Applies to 9th grade students only (REVISED)
- Screening must occur no earlier than 1 year prior to enrollment and no later than 4 months after enrollment (REVISED)
- Screenings can only be performed by: dentists or dental hygienists

A+

ABC's

Local I-Smile Oral Health Coordinators are working with schools throughout the state to help implement the requirement - including assisting families to get children screened and finding follow-up care as needed.

To find your local I-Smile Coordinator, go to:
www.idph.state.ia.us/webmap/default.asp?map=ismile

Required forms and additional information on the school dental screening requirement can be found at:
www.idph.state.ia.us/hpcdp/oral_health_school_screening.asp

