Certificate of Dental Screening - Valid one year from enrollment. Must be filled out by dental office.

IOWA | Health and Human Services

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 (MM/DD/YY):

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 decay[1] or a white spot lesion[2] is suspected in one or more teeth, or gum infection[3] is suspected.

☐ **Requires Urgent Dental Care**— obvious tooth decay[1] 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; Ninth-grade 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: _____

*Recorder: An authorized provider (DDS/DMD, RDH MD/DO, PA, or RN/ARNP) may transfer information on this form from another health department. 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.

Iowa Department of Health and Human Services • Bureau of Family Health – Oral Health Section

1-866-528-4020 • *https://hhs.iowa.gov/programs/programs-and-services/dental-and-oral-health*

A designee of the local Board of Health or Iowa Department of Health and Human Services may review this certificate for survey purposes.

Rev. 8/24

JESUP COMMUNITY SCHOOL – ANNUAL STUDENT HEALTH HISTORY UPDATE

****** SUBMIT HERE ONLINE IF POSSIBLE ******

Name of Student:_____Birthdate: _____ Gender:_____ Grade:_____

1. Does this child have any vision, hearing or speech concerns that the school should be aware of?

   ☐ No ☐ Yes: please explain_____

2. Does this child have a chronic health condition that may require immediate medical attention (i.e. asthma, diabetes, seizures, fainting, allergies such as food, insects, medication)?

   ☐ No ☐ Yes: please explain and include if any emergency medication will be stored at school

   _____

   _____

3. Does your child have any other health conditions that will impact their education or activity for this school year?

   ☐ No ☐ Yes: please explain_____

   _____

4. Does this child have dietary accommodation ordered by your provider? (i.e. Drinking milk - constipation) If yes, this REQUIRES A ONE TIME DIET MODIFICATION FORM signed by provider

   ☐ No ☐ Yes: please

   explain:_____

5. Will this child need to take prescription medication during the school day? If yes, please email Nurse Missy at mwalztoni@jesup.k12.ia.us for further guidance.

   ☐ No ☐ Yes

6. Do you give permission for this child to receive a weight appropriate dose of acetaminophen and ibuprofen if deemed necessary by school staff? ** Nurse will call home before giving it to elementary students. PLEASE NOTE: If a student requires over-the-counter medications more than 8 times during the school year, further written permission from a healthcare provider will be required before additional doses are given.

   ☐ No ☐ Yes

7. Do you give permission for this child to receive over the counter products such as antacids, cough drops, Vaseline, lotion, saline eye drops, ointments such as hydrocortisone, Benadryl cream, or antibiotic ointment? ☐ No ☐ Yes

8. Do you grant permission for your students' health information to be shared with appropriate staff to meet their health and safety needs? ☐ No ☐ Yes:

Signature of Parent/Guardian:_____ Date: _____

Parent/Guardian Emergency Phone:_____Hospital Preference: _____

If this number changes during the school year, notify the school office immediately.