Elmira City School District



Administration Building 430 W. Washington St. Elmira, NY 14901

Phone: (607) 735-3000 www.elmiracityschools.com

Date:	School:
Student:	Grade:
Dear Parent or Guardian,	
·	of overall health. Dental problems can make it school, can lead to other health problems, and steem issues.
·	te of dental health for your son or daughter: district - at PreK, Kindergarten, or at any other
<mark>once it is completed, please return it</mark> any examination done on or after Se	ificate for you to take to your child's dentist; to the school nurse. Your dentist may document pt. 1, 20 The certificate will be filed in d at school. Please call the school health office ave questions or concerns.
School fax number:	
Thank you for your help. We apprecion good health. This can really help him	ate your willingness to ensure your child's overall n/her to be successful in school!
(Also, please keep an eye out in tl provided at school. Most insurance p	he fall for information about dental services plans accepted.)
Sincerely, Your School Nursing Staff	

4/19 595.47

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)					
Child's Name: Last		First	Middle		
Birth Date: / / Month Day Year	Sex: Male	Will this be your c	nild's first oral health assessment?	☐ Yes ☐ No	
School: Name	□ Female			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					
I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health. I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship.					
Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.					
Parent's Signature_			Date		
Sect	tion 2. To be com	pleted by the D	entist/ Dental Hygienist		
I. The dental health condition of on (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:					
\square Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.					
□ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.					
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 the public school does not preclude the student from attending school.					
Dentist's/ Dental Hygienist's name and address					
(please print or stamp) Dentist's/Dental Hygienist's Signature					
Optional Sections - If you agree to rele	ase this information t	to your child's sch	ool, please initial here.		
II. Oral Health Status (check all that apply). ☐ Yes ☐ No Caries Experience/Restoration History – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].					
□ Yes □ No Untreated Caries – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].					
☐ Yes ☐ No Dental Sealants Present Other problems (Specify):					
II. Treatment Needs (check all that apply)					
□ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.					
 □ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation. 					
□ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.					