

**STATE LAW  
FOR: KINDERGARTEN & 9<sup>TH</sup> GRADE STUDENTS ONLY**



**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 decay<sup>1</sup> or a white spot lesion<sup>2</sup> is suspected in one or more teeth, or gum infection<sup>3</sup> is suspected.

**Requires Urgent Dental Care** – obvious tooth decay<sup>1</sup> is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

<sup>1</sup> Tooth decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.

<sup>2</sup> 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.

<sup>3</sup> 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) \_\_\_\_\_ **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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