



STUDENT HEALTH SCREENINGS

The Pennsylvania Department of Health requires that every child of school age attending public or non-public schools must be provided with various health screenings. Listed below is a schedule for the required screenings.

Dental Screening

Dental diseases are the most prevalent chronic conditions of children in the United States and the major cause of loss of teeth in children and adolescents. Dental diseases account for much pain and disruption of time and attention in school. Dental diseases untreated are progressively destructive of teeth, gums and bony supporting structures.

Dental disease is largely preventable by the practice of appropriate dental and oral hygiene care. Schools have played a considerable role in delivery of dental services to children from the earliest days of school health. The school dental health program in Pennsylvania is an integral part of the total school health program.

The mandated dental examination program represents the minimum dental health services which students in specified grades must receive. The dental examination provides baseline data for determining the dental health status of the pupil population served.

Parents/guardians are encouraged to have their family dentist perform the examinations and report the results of the examination on approved forms provided by the school and returned to the school to be included in the comprehensive school health record. Examinations done by the family dentist within four months prior to the opening of school are accepted for the required examination that year.

Annual dental screenings are required for students in kindergarten, first, third and seventh grades.

Please be prompt in returning the examination form so that the School Nurse can keep your child's school health record updated.

If you have any questions regarding this process, please contact Mrs. Tina Vojtko, RN at 820-4070, extension 313.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

**PRIVATE DENTIST REPORT OF
DENTAL EXAMINATION OF A PUPIL OF
SCHOOL AGE**

NAME OF SCHOOL _____ DATE _____ 19__

| | | | | | | |
|---------------|-------|--------|-----|---|-------|--------------|
| NAME OF CHILD | | | AGE | SEX | GRADE | SECTION/ROOM |
| Last | First | Middle | | <input type="checkbox"/> M <input type="checkbox"/> F | | |

ADDRESS _____

| | | | | | |
|----------------|---------------------|---------------------|--------|-------|-----|
| No. and Street | City or Post Office | Borough or Township | County | State | Zip |
|----------------|---------------------|---------------------|--------|-------|-----|

REPORT OF EXAMINATION

| | TOOTH CHART | | | | | | | | | | | | | | | | |
|-------|-------------|----|----|---|---|---|---|---|------|----|----|----|----|----|----|----|-------|
| | RIGHT | | | | | | | | LEFT | | | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | |
| UPPER | | | | A | B | C | D | E | F | G | H | I | J | | | | Upper |
| LOWER | 32 | 31 | 30 | T | S | R | Q | P | O | N | M | L | K | 19 | 18 | 17 | Lower |
| UPPER | | | | | | | | | | | | | | | | | Upper |
| LOWER | | | | | | | | | | | | | | | | | Lower |

Is The Child Under Treatment Yes No

Treatment Completed Yes No

Date of Dental Examination

Signature of Dental/Examiner

Print Name of Dental Examiner

Address