CERTIFICATE OF DENTAL EXAMINATION

Must be completed by a dentist
Required for all new students, transfer students, or kindergarteners.
MCA must have at least one dental exam on file for each enrolled student.

Student Name: ____ Date of Birth: ______________________

To Be Completed by Dentist:

Date of Last Dental Exam: ____

Oral Health Exam

Dental Sealants Present	☐ YES	☐ NO
Cavities Present	☐ YES	☐ NO
Poor Oral Hygiene	☐ YES	☐ NO
Soft Tissue Pathology	☐ YES	☐ NO
Malocclusion	☐ YES	☐ NO

Treatment Needs

Urgent Treatment (abscess, pain, infection)	☐ YES	☐ NO
Restorative Care (amalgams, composites, crowns, etc.)	☐ YES	☐ NO
Preventative Care (sealants, fluoride, prophylaxis)	☐ YES	☐ NO

Other: ____

Does this patient currently have any tooth decay or other dental issues that may reduce his/her efficiency or prevent him/her from receiving the full benefit of his/her school work?

☐ NO

☐ YES – please explain: ____

Signature of Dentist: ____ Date: _________________________

Printed Name of Dentist: ______________________________ Phone: ____________________