

**CITY SCHOOL DISTRICT OF ALBANY  
BUREAU OF HEALTH AND PHYSICAL EDUCATION**

**Dental Health Certificate**

Parent/Guardian: New York State Law requires school districts to request Dental Certificates for students when they enter school and in grades K, 2, 4, 7, and 10. Please complete Section 1 of this form and have your child's dental care provider complete Section 2. The dental assessment may be completed during or 12 months prior to the school year in which it is required. Return the completed form to the School Nurse/Teacher by *January 1st*.

**Section 1. To be completed by Parent or Guardian (Please Print)**

Child's Name: (Last, First, Middle)

Birth Date: \_\_\_ / \_\_\_ / \_\_\_  
Month /Day /Year

Sex: Male  
Female

Will this be your child's first visit to a dentist? Yes No

School:

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

**Section 2. To be completed by the Dental Care Provider**

Child's Name: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

**The dental exam may be completed during or 12 months prior to the school year in which it is required.**

**Check one:**

Yes - The student listed above is in fit condition of dental health to permit his/her attendance at school.

No - The student listed above is not in fit condition of dental health to permit his/her attendance at school.

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 school does not preclude the student from attending school.

Dental Care Provider's Name & Address: \_\_\_\_\_

Stamp:

Dental Care Provider's Signature: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Oral Health Status** (check all that apply).

**Caries Experience/Restoration History:** Yes No

Has the child ever had a cavity (treated or untreated) or extraction?

**Untreated Caries:** Yes No

Does this child have an open cavity?

**Dental Sealants Present** Yes No

**Fluoride Supplements:** Yes No

**Other Observations (Specify):** \_\_\_\_\_

**Treatment Needs (check all that apply)**

No obvious problem. Routine dental care is recommended.

Immediate dental care is required.

Requires an appointment with a dentist for further care.

Date of Appointment: \_\_\_\_\_

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Dear Parent or Guardian:

Poor dental health can cause pain, lead to significant life-long health problems, and can be a barrier to academic achievement.

New York State Law requires school districts to request Dental Certificates for students when they enter school and in **grades K, 2, 4, 7, and 10**.

Please take this form to your child's dental care provider to be completed. The dental assessment may be completed during or 12 months prior to the school year in which it is required.

Please return the completed form to your School Nurse/Teacher. The results will be maintained in the permanent health record.

If you have questions or do not have a dental care provider for your child, please contact the School Nurse/Teacher for assistance.

Thank you for your cooperation.

\_\_\_\_\_  
School Nurse/Teacher

Telephone Number: \_\_\_\_\_