

# Dental Health Certificate

**Parent/Guardian:** New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. 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:	/	/	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first oral health assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			Month	Day	Year
School: Name					Grade
Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? <input type="checkbox"/> Yes <input type="checkbox"/> 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

## Section 2. To be completed by the Dentist/ 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:**

- ☐ 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**

The Smile Lodge  
713 Pierce Road  
Clifton Park, NY 12065

**Optional Sections - If you agree to release this information to your child's school, please initial here.**

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### 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.



# CHILD CARE AUTHORIZATION

713 PIERCE ROAD  
CLIFTON PARK, NY 12065  
(518) 373-1181 FAX: (518) 373-0130  
WWW.SMILELODGE.COM

I, \_\_\_\_\_, THE PARENT OR GUARDIAN OF THE  
BELOW NAMED MINORS, AND LEGALLY ENTITLED TO GIVE THIS AUTHORIZATION,  
GRANT TEMPORARY AUTHORITY TO \_\_\_\_\_,  
LIMITED TO THE BELOW DEFINED POWERS, OVER THE FOLLOWING CHILDREN:

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THE POWERS GRANTED ARE LIMITED TO THE FOLLOWING (PLEASE CHECK):

- ☐ TO SEEK ROUTINE (EXAM & CLEANING) DENTAL CARE FOR THE CHILDREN NAMED
- ☐ TO SCHEDULE ROUTINE HYGIENE APPOINTMENTS
- ☐ TO AUTHORIZE DIAGNOSTIC X-RAYS WHERE INDICATED
- ☐ TO AUTHORIZE FLUORIDE VARNISH TREATMENT
- ☐ TO DISCUSS WITH THE DOCTOR AND OFFICE STAFF PROTECTED HEALTH INFORMATION

THIS GRANT OF AUTHORITY IS EFFECTIVE AS OF \_\_\_\_\_ AND SHALL  
REMAIN IN EFFECT UNTIL TERMINATED BY THE UNDERSIGNED PARENT OR GUARDIAN.

THIS GRANT OF AUTHORITY IS SIGNED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_  
IN THE COUNTY OF \_\_\_\_\_, IN THE STATE OF NEW YORK.

SIGNED,

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LEGAL GUARDIAN



# RECORDS RELEASE REQUEST

713 PIERCE ROAD  
CLIFTON PARK, NY 12065  
(518) 373-1181 FAX: (518) 373-0130  
WWW.SMILELODGE.COM

PATIENT'S NAME (PLEASE PRINT): \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

DESCRIPTION OF RECORDS YOU WISH TO ACCESS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

☐ I WISH TO SEE THE REQUESTED RECORDS

☐ I WISH TO RECEIVE A COPY OF THE REQUESTED RECORDS

☐ I WISH TO AUTHORIZE A RELEASE OF THE REQUESTED RECORDS TO THE  
BELOW NAMED PARTY

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

☐ I WISH TO AUTHORIZE A RELEASE OF THE REQUESTED RECORDS  
(VIA SECURE E-MAIL) TO THE ADDRESS LISTED BELOW

E-MAIL: \_\_\_\_\_

☐ I WISH TO AUTHORIZE A RELEASE OF THE REQUESTED RECORDS TO THE  
FAX NUMBER BELOW: (PLEASE NOTE: X-RAYS CANNOT BE FAXED)

FAX: \_\_\_\_\_

I, \_\_\_\_\_ HEREBY AUTHORIZE THE SMILE LODGE PEDIATRIC DENTISTRY  
TO RELEASE THE REQUESTED RECORDS OF THE PATIENT IDENTIFIED ABOVE, TO THE  
DESIGNATED NAME, ADDRESS OR E-MAIL.

\_\_\_\_\_  
{PLEASE PRINT NAME}

\_\_\_\_\_  
{RELATIONSHIP TO PATIENT}

\_\_\_\_\_  
{SIGNATURE}

\_\_\_\_\_  
{DATE}

PRIVACY OFFICIAL: JANICE LANCTO  
713 PIERCE ROAD  
CLIFTON PARK, NY 12065  
TELEPHONE: (518) 373-1181  
FAX: (518) 373-0130

PLEASE CONTACT OUR PRIVACY OFFICIAL LISTED ABOVE IF YOU HAVE ANY QUESTIONS RE-  
GARDING YOUR REQUEST TO INSPECT, TRANSFER, OR OBTAIN RECORDS.