



**HAWAII NATIONAL GUARD YOUTH CHALLENGE ACADEMY**

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**CERTIFICATE OF DENTAL SCREENING**

**This certificate is not valid unless all fields are complete.**

**Information (please print)**

<b>Last Name:</b>	<b>First Name:</b>	<b>Birth Date (MM/DD/YYYY):</b>
<b>Parent or Guardian Name:</b>		<b>Telephone (Home or Mobile):</b>
<b>Street Address:</b>		<b>City and State:</b>
<b>Name of High School currently attending:</b>	<b>Grade:</b>	<b>Gender:</b> <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 or a white spot lesion is suspected in one or more teeth, or gum infection is suspected.
- REQUIRES URGENT Dental Care** – obvious tooth decay is present in one or more teeth, there is evidence of injury or sever 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 gum line. 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**

**Provider Name: (please print)** \_\_\_\_\_ **Provider Business Phone:** \_\_\_\_\_

**Provider Business Address:** \_\_\_\_\_

**Signature and Credential of Provider or Recorder\*:** \_\_\_\_\_

**Date signed:** \_\_\_\_\_

\*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.