Head Start
Early Head Start

DENTAL EXAMINATION

CHILD'S LEGAL NAME: ____ DOB: ______________

PARENT/GUARDIAN: ____

Dental History (*include any problems with teeth, gums, mouth or speech)***:**____________________________

____

Fluoridated water? ____ Fluoride Supplement? _______

Is this child up to date on age appropriate dental visits? ______Yes ______No

Date of Examination: ___________________

Exam Normal: _____ Needs Restorative Treatment: ______ Appointment Scheduled: ______

Restorative Treatment in Progress: _____ Restorative Treatment Completed: ______

Child Had: _____ Topical Fluoride

_____ X-Rays

_____ Prophylaxis

_____ Sealants

_____ Dental Hygiene Instruction

Recommendations for Follow-Up:____

____

Dentist Signature:____ **Date:** ____________________
Clinic: ____
Address: ____
____ Phone: ___________________

HS-330
(7/13) Reviewed (6/2016)

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Reach-Up Head Start and Early Head Start provides comprehensive education and support services that strengthen young children and their families who are experiencing low-income.