



HEAD START CHILD HEALTH RECORD:

DENTAL HEALTH



Child's Name:	Age:	DOB:
Head Start Center:	Rm:	
Address:	Phone:	

To be completed by parent

Does the child have any trouble with teeth, gums, or mouth that the parent knows about that dental health provider should be aware of? No Yes, Explain:

To be completed by teacher

Has teacher identified any problems with teeth, gums, or mouth that dental health provider should be aware of? No Yes, Explain:

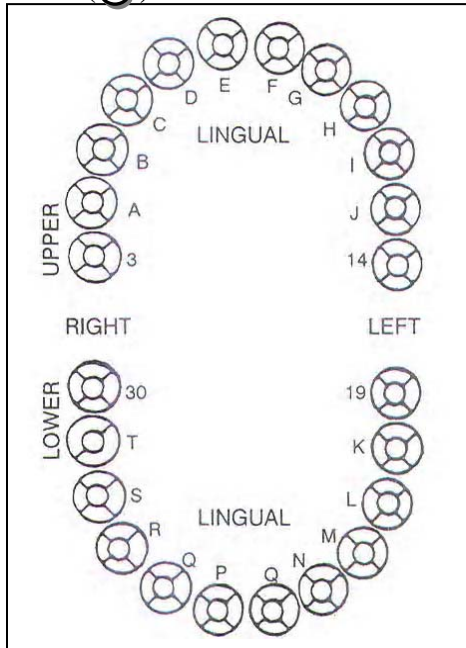
To be completed by parent

Teacher has informed me about the above problems & has advised me to seek treatment.

Parent Signature: _____ Date: ___ / ___ / ___

To be completed by Dental Health Provider

Oral conditions before treatment:
 Missing (⊗), Decayed (●),
 Filled (⊗)



Examination included all the following: (please check all that apply)

<input type="checkbox"/>	All the Following	<input type="checkbox"/>	Cleaning
<input type="checkbox"/>	Exam	<input type="checkbox"/>	X-Rays
<input type="checkbox"/>	Fluoride Treatment	<input type="checkbox"/>	Other:

Follow Up Work:

Tooth # or letter	Surfaces	Description of Work Needed	Next Appt. Date

All planned treatment:

<input type="checkbox"/>	Is complete	<input type="checkbox"/>	Is not complete
Comments:			

Clinic:	Dental Health Provider Signature:	Date of exam:
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