Olentangy Preschool

ANNUAL DENTAL SCREENING

THIS FORM MUST BE COMPLETED, SIGNED AND DATED

FORM REQUIRED WITHIN 60 BUSINESS DAYS OF ENTRANCE INTO THE PRESCHOOL PROGRAM AND ANNUALLY THEREAFTER

Child's Name: _________________________________ Date of Birth: ______________________

Check One:

☐ **Dental Screening Completed** Date of Screening ___________________________

_____________________________________ _____________________________
Dentist's Name (please print) Phone Number

_____________________________________ _____________________________
Dentist's Signature Date

____
Dentist's Street Address

____
City, State, Zip Code

☐ **Dental Screening Not Completed** State Reason:_________________________________

Examples: No insurance coverage, religious conviction, child too young, etc.

_____________________________________ _____________________________
Parent Signature Date

Return to your preschool building nurse
OR fax to 740-657-4696

Updated 4/6/2018