DENTAL EXAMINATION FORM

Please return exam results to:

Davis School District Head Start/Early Head Start
320 S. 500 E. • Kaysville, UT 84037 • 801-402-0650 • Fax 801-402-0651

PARENTS: Head Start requires your child receives a dental examination. Follow-up work must also be completed if needed. Please fill out your child's name and date of birth and take this to your child's dental appointment. **Remember Head Start needs a copy of this completed form.**

(Head Start requiere que su niño reciba un examen dental. Si necesita tratamiento adicional, es requerido que se cumpla el tratamiento. Por favor llene el nombre de su niño y su fecha de nacimiento y lleva este forma a la cita del examen dental. La oficina dental llenará la porción de abajo. **Regrese esta forma completa a Head Start.**

Child's Name: ____ **Date of Birth:** _____________
(Nombre del Niño) (Fecha de Nacimiento)

DENTIST: Please fill out the following information.

Exam Date: _______________

Name of Clinic and phone number or clinic stamp:____________________________________

Services received:

Examination __________ Cleaning __________ Fluoride__________ X-ray __________

Results of the exam were: Please check one of the following and indicate next recommended visit.

☐ This exam completed services. Next appointment has been scheduled for: _______________
Date

If no appointment scheduled, it is recommended child return in:
☐ 6 month ☐ 12 months ☐ Other ___________

☐ Further dental work is needed.
The patient has an appointment for this work on: _______________________________

The approximate amount is $___________________________________
(Please attach a copy of the treatment plan if possible.)

Treatment has been received. Date completed: _________________________________

Dentist's Signature:____________________________________

NOTE: After completion please fax or email directly to Head Start at fax # 801-402-0651 or fecregistration@dsdmail.net .