

**DEER PARK SCHOOLS HEALTH RECORD  
DENTIST'S REPORT**

**CHILD'S NAME** \_\_\_\_\_

\_\_\_\_\_ **DATE OF BIRTH**

The following services have been performed:

- \_\_\_\_\_ Examination
- \_\_\_\_\_ Diagnosis
- \_\_\_\_\_ Radiographs
- \_\_\_\_\_ Oral prophylaxis
- \_\_\_\_\_ Prescription for fluoride supplements
- \_\_\_\_\_ Topical application of fluoride

The following oral hygiene instruction was provided:

- \_\_\_\_\_ Tooth brushing
- \_\_\_\_\_ Flossing
- \_\_\_\_\_ Diet counseling reflecting relation of diet to dental health
- \_\_\_\_\_ Home/school

The following statements are applicable:

- \_\_\_\_\_ All necessary services have been performed
- \_\_\_\_\_ No restorative services are required at this time
- \_\_\_\_\_ Further treatment is indicated
- \_\_\_\_\_ Further appointments have been arranged

**COMMENTS:**

\_\_\_\_\_  
\_\_\_\_\_

\*\*\*\*\*

PLEASE PRINT OR STAMP

Dentist's name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Date: \_\_\_\_\_

Dentist's Signature: \_\_\_\_\_