

Child's Name: _____

**OHIO SCHOOL HEALTH RECORD
DENTIST'S REPORT**

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:

- _____ Toothbrushing
- _____ Flossing
- _____ Diet counseling reflecting relation of diet to dental health
- _____ Home/school use of fluoride mouth rinse

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 _____

Dentist's signature _____

Date signed _____