Early Childhood
Education Program

Verification of Dental Treatment

Child's Name: ______________________________________ Date of Birth: ____________

School:____

Guardian's Name: ____________________________________

Has your child ever been seen by a dentist? ☐ Yes ☐ No

Name of Dentist/Dental Practice: ____

Date of last dental exam: _______________________

☐ Needs no treatment at this time

☐ Needs a routine examination in the month of ________________

☐ Needs the following services____
____

☐ Appointment scheduled for _______________________

Additional Comments:
____
____

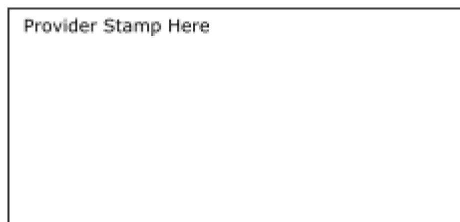
Decline Dental Services for my child at this time ________________ ______________
(Parent/Guardian Initials) (Date)

Does your child have dental insurance? ☐ Yes ☐ No

What is the name of dental insurance? ____

Is your child now receiving:
Topical Fluoride Application ☐ Yes ☐ No ☐ Unknown
Fluoridated water? ☐ Yes ☐ No ☐ Unknown
Fluoride Supplement diet? Yes:(☐ tablets ☐ liquid) ☐ No ☐ Unknown

Signature of Dentist: ______________________________________ **Date:** __________



Please return this form to your child's school.

Updated 1/5/22