SYCAMORE COMMUNITY SCHOOLS
Our students. Our future.

DENTAL REPORT

To be completed by student's dentist.

Today's Date _____

Name of Child _____

Date of Birth _____ School _____ Grade _____

The following services have been performed (please check all that apply):

_____ X-rays

_____ Oral prophylaxis

_____ Fluoride treatment

_____ Restorations

The following statements are applicable:

_____ All necessary services have been performed.

_____ No restorative services are required at this time.

_____ Further treatment is indicated.

_____ Future appointments have been arranged.

Additional Comments:

_____

_____

_____

_____

_____

Signature of Dentist **Date**

_____

Printed Name of Dentist **Date**

Rev. 6/08