

Ohio School Health Record Dentist's Report

Child's Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date
--------------	--	-----	------

<p>The following services have been performed:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Examination</td> <td style="width: 33%;"><input type="checkbox"/> Radiographs</td> <td style="width: 33%;"><input type="checkbox"/> Prescription for fluoride supplements</td> </tr> <tr> <td><input type="checkbox"/> Diagnosis</td> <td><input type="checkbox"/> Oral prophylaxis</td> <td><input type="checkbox"/> Topical application of fluoride</td> </tr> </table>	<input type="checkbox"/> Examination	<input type="checkbox"/> Radiographs	<input type="checkbox"/> Prescription for fluoride supplements	<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Oral prophylaxis	<input type="checkbox"/> Topical application of fluoride
<input type="checkbox"/> Examination	<input type="checkbox"/> Radiographs	<input type="checkbox"/> Prescription for fluoride supplements				
<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Oral prophylaxis	<input type="checkbox"/> Topical application of fluoride				

<p>The following services have been performed:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Toothbrushing</td> <td style="width: 50%;"><input type="checkbox"/> Diet counseling reflecting relation of diet to dental health</td> </tr> <tr> <td><input type="checkbox"/> Flossing</td> <td><input type="checkbox"/> Home/school use of fluoride mouthrinse</td> </tr> </table>	<input type="checkbox"/> Toothbrushing	<input type="checkbox"/> Diet counseling reflecting relation of diet to dental health	<input type="checkbox"/> Flossing	<input type="checkbox"/> Home/school use of fluoride mouthrinse
<input type="checkbox"/> Toothbrushing	<input type="checkbox"/> Diet counseling reflecting relation of diet to dental health			
<input type="checkbox"/> Flossing	<input type="checkbox"/> Home/school use of fluoride mouthrinse			

<p>The following services have been performed:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> All necessary services have been performed</td> <td style="width: 50%;"><input type="checkbox"/> Diet counseling reflecting relation of diet to dental</td> </tr> <tr> <td><input type="checkbox"/> No restorative services are required at this time</td> <td><input type="checkbox"/> Further appointments have been arranged</td> </tr> </table>	<input type="checkbox"/> All necessary services have been performed	<input type="checkbox"/> Diet counseling reflecting relation of diet to dental	<input type="checkbox"/> No restorative services are required at this time	<input type="checkbox"/> Further appointments have been arranged
<input type="checkbox"/> All necessary services have been performed	<input type="checkbox"/> Diet counseling reflecting relation of diet to dental			
<input type="checkbox"/> No restorative services are required at this time	<input type="checkbox"/> Further appointments have been arranged			

<p>Comments: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
--

Please print or stamp

Dentist's Name	Dentist's Signature
Address	Date Signed
Phone	