Englewood SCHOOLS | Building a New Tradition of Excellence

VERIFICATION OF DENTAL EXAM

*This form **MUST** be completed and returned to the Englewood ECE Program at Maddox within **60 DAYS** after enrollment. Please contact the ECE Family Service Liaison or the ECE Health Assistant if you need help finding a pediatric dentist.*

Dental exams are needed every 6 months per Head Start Funding.

PARENT: To be completed by the parent/guardian

Child's Name: _____ **Date of Birth:** _____

I, _____, give permission for my child's health provider and school to discuss my child's oral health concerns. My child's health provider may fax this form (and applicable attachments) to my child's school.

Please return the completed form via fax, mail, or bring it to:
Englewood Early Childhood Education at Maddox, 3838 S. Huron St., Englewood, CO 80110
Phone: 303.781.7585 | Fax: 303.806.2535

_____ Date: _____
Parent or Legal Guardian Signature

DENTAL CARE PROVIDER: To be completed after the parent section

Oral Health Provider, please complete this important oral health form as it is a record of:

⦿ Dental home status for this child. ⦿ Current dental concerns.
⦿ What oral health care services were received at this visit, and what services are still needed.

Current Oral Health Status **Dental Exam Date:** _____

Is this practice the child's dental home? ☐ Yes ☐ No
Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No
Does the Child have any teeth with untreated decay? ☐ Yes ☐ No
Are treatments needed? ☐ Yes, Urgent ☐Yes, Not Urgent ☐ No treatments needed
What are the needed treatments? _____

Oral Health Care Services Received This Visit

Diagnostic/Preventative Services

Examination:	☐ Yes	☐ No
X-rays:	☐ Yes	☐ No
Risk Assessment:	☐ Yes	☐ No
Cleaning:	☐ Yes	☐ No
Fluoride Varnish:	☐ Yes	☐ No
Dental Sealants:	☐ Yes	☐ No

Restorative/Emergency Care

Fillings:	☐ Yes	☐ No
Crowns:	☐ Yes	☐ No
Extractions:	☐ Yes	☐ No
Emergency Care:	☐ Yes	☐ No

Counseling/Additional Guidance: ☐ Yes ☐ No
Referral to Specialty Care: ☐ Yes ☐ No
If Yes, specify specialist:_____

Future Oral Health Care Services
All treatment completed: ☐ Yes ☐ No **Next Appointment Date**:
_____

Additional Comments: _____
_____

Provider's Office Stamp:
Or write name, address, and phone number

_____ Date: _____

Updated November 2025

Signature of Dental Care Provider