Educational Service Center of Lake Erie West
Early Childhood Program

Dental Form

MAY BE FAXED TO 419-725-2063

Child's Name _____ Date of Birth _____

Address _____

Parent/Guardian Name _____

Dental Examination

Oral Hygiene

1. Excellent 0
2. Average 0
3. Poor—reviewed home care 0

Prophylaxis **Date**

1. Exam _____
2. Fluoride _____
3. X-rays _____

Recommendations following examination

1. Treatment necessary 0
2. Treatment completed 0
3. No treatment necessary 0
4. Treatment not completed 0

Remarks

_____

_____

Dentist Name _____

Signature _____

Address _____

Phone and fax number _____

Medical and dental forms are valid for 13 months after the date of examination. This form may need to be updated during the school year.