Preschool Child Dental Form

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschool Classroom site:</td>
<td>Gender: □ Male □ Female</td>
</tr>
</tbody>
</table>

Date of Dental Exam: ____________________________

☐ Cleaning    ☐ Fluoride treatment

Treatment needs: (check only one based on exam results)

☐ No obvious problems: The child’s hard and soft tissues appear to be visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.

☐ Requires Dental Care: Tooth decay or gum infection is suspected. *

☐ Requires Urgent Dental Care: Obvious tooth decay is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain. *

Next scheduled recall visit: ____________________________

*Follow up Treatment:

☐ Treatment is scheduled for ____________________________

☐ Child was referred to _________________________________ for treatment

Provider Name (please print): _____________________________ Provider Business Phone: _________

Provider Business Address: ______________________________________________________________

Signature and Credentials of Provider: ____________________________ Date: __________

Please return completed form to:

NICAO Head Start, 1190 Briarstone Drive, Mason City IA 50401 or fax to 641-494-1894

3/22/11