Orange County Head Start, Inc.

Required Oral Examination Form

Name of Child _____ **Birth date** _____

Name of Parent_____

Utilizing this form, please provide up-to-date information on the child referenced above.

Exchange of Information/Intercambio de Información

As the parent of the child referenced above, I hereby authorize the release of the information contained in this document to be provided to Orange County Head Start, Inc.

Como el padre/tutor del niño identificado en este formulario, yo autorizo el intercambio de información médica que se encuentra en este documento a Orange County Head Start, Inc.

Parent Signature/*Firma de Padre*_____ Date/*Fecha* _____

To the Dentist

The above named child is participating in the Head Start program and is required to submit evidence of a dental examination performed within the last twelve months. After the examination results are recorded, please return the completed form to the parent.

DATE OF EXAM_____ **DATE OF NEXT APPOINTMENT IF REQUIRED**_____

	Please Indicate All Applicable Statements	Check Below
1	X-Rays, Examination and Diagnosis, Prophylaxis and Topical Fluoride	
2	Surface Filling (number needed)	
3	Stainless Steel Crown (number needed)	
4	Pulpotomy (number needed)	
5	Extraction (number needed)	
6	Other (specify)	

Treatment Status: ☐ **No Treatment Needed** ☐ **Completed** ☐ **Not completed**

Follow-up Status of Dental Treatment (Provider Use Only)

Follow-up Treatment Date: _____ **Treatment Completed**: ☐ Yes ☐ No

Staff Initials: _____ Date: _____

Follow-up Treatment Date: _____ **Treatment Completed**: ☐ Yes ☐ No

Staff Initials: _____ Date: _____

Dentist Information (Stamp)
Name:
Address:
Phone:

Signature: _____

Date: _____

Fax: _____