

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.

Là Phụ huynh của con tôi sau đây. Tôi bằng lòng cung cấp những thông tin sức khoẻ trong văn bản này cho cơ quan Quận Cam Head Start, Inc.

Parent Signature/ Phụ Huynh Ký tên _____ Date/ Ngày _____

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: _____