

Preschool Child Dental Exam Form

Child's Name	Date of Birth:
Preschool Classroom site:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/>

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. *

*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