

Student's Full Name: _____ **Exam Date:** _____

Gender: Male or Female **DOB:** _____ **Age:** _____

Pre-school and Kindergarten students must have a current (within 1 year) physician's exam on file prior to admission & renewed every year during the named grades

The following services have been performed:

- | | | |
|------------------------------------------------------|-------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Examination by Dentist | <input type="checkbox"/> Orthodontic Assessment | <input type="checkbox"/> Oral Screening |
| <input type="checkbox"/> Dental Sealants | <input type="checkbox"/> Radiographs | <input type="checkbox"/> Fluoride Application |
| <input type="checkbox"/> Oral Prophylaxis (cleaning) | <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Rx for fluoride supplements |

The following oral hygiene instruction was provided:

- | | |
|-----------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> Brushing teeth | <input type="checkbox"/> Diet counseling related to dental health |
| <input type="checkbox"/> Flossing | <input type="checkbox"/> Home/school use of fluoride mouth rinse |

The following statements are applicable:

- ☐ No apparent care needed at this time.
- ☐ All necessary preventative services have been performed. (Fluoride treatment, prophylaxis)
- ☐ No restorative services are required at this time.
- ☐ Further treatment is indicated. (See comments)
- ☐ Further appointments have been arranged. (ex. Orthodontic, restorative)

Comments: _____

Examiner's Signature: _____

Examiner's Printed Name: _____

Dental Office Address: _____

Telephone: _____ **Fax:** _____

Please return this copy to your child's school or the Welcome Center