Preschool Child Dental Form

Child's Name	Date of Birth:
Preschool Classroom site:	Gender: ☐ Male ☐ Female

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