Akron Children's Hospital
SCHOOL HEALTH SERVICES

Dentist Report

Child's Name: _____ B**irth Date:** _____

The following services have been performed:

_____ Examination Date of Exam: _____

_____ Radiographs _____ Prescription for fluoride supplements

_____ Diagnosis _____ Oral prophylaxis _____ Topical application of fluoride

The following oral hygiene instruction was provided:

_____ Toothbrushing _____ Diet counseling

_____ Flossing _____ Home/school use of fluoride mouth rinse

The following statements are applicable:

_____ All necessary services have been performed
_____ Further treatment is indicated
_____ No restorative services are required at this time
_____ Further appointments have been arranged

Comments:

Please Print or Stamp:

Dentist's Name:	**Signature:**
Address:	**Date Signed:**
Phone:	

Please return this completed and signed dentist form to your child's school clinic.