Akron Children's Hospital
SCHOOL HEALTH SERVICES

Dentist Report

Child's Name: ____ **Birth 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.