Los Angeles County Office of Education
Leading Educators ▪ Supporting Students ▪ Serving Communities

Head Start - State Preschool

DENTAL EXAM FORM

PROGRAM CHILD IS ENROLLED IN
☐ Head Start ☐ Early Head Start
☐ Center Base ☐ Home Base ☐ FCC

LAST NAME, FIRST NAME, MIDDLE INITIAL OF CHILD	SEX ☐ M ☐ F	DATE OF BIRTH	NAME OF PARENT OR GUARDIAN

DELEGATE AGENCY NAME/SITE

TO BE COMPLETED BY DENTIST
(THIS IS NOT A BILLING FORM)

DENTAL EXAMINATION ADMINISTERED BY (TYPE OR PRINT NAME)

SIGNATURE	TELEPHONE NUMBER

ADDRESS

DENTAL SERVICES PROVIDED

Dental Examination ☐ Yes ☐ No **Date of Exam** _____

Preventive Dental Care Provided (including Fluoride &/or Anticipatory Guidance) ☐ Yes ☐ No

DESCRIBE PREVENTIVE CARE

DENTAL DIAGNOSIS

☐ **Normal Examination/No Treatment Needed**
☐ **Dental Treatment Needed**
Dental Diagnosis:
☐ **Cavities** **Number of Cavities** _____ ☐ **Early Childhood Caries (ECC)**
☐ **Other Diagnosis** _____

DENTAL TREATMENT

Dental Treatment Initiated ☐ Yes ☐ No
Describe Dental Treatment _____
Has all Dental Treatment Been Completed? ☐ Yes ☐ No
Date of Next Visit for Treatment _____

NEXT DENTAL EXAMINATION

Date Next Routine Dental Examination Due _____

TO BE COMPLETED BY HEAD START STAFF

SIGNATURE OF STAFF COMPLETING 1ST REVIEW	POSITION	DATE
SIGNATURE OF STAFF COMPLETING 2ND REVIEW	POSITION	DATE

HEAD START FOLLOW-UP

REFERRED FOR FOLLOW-UP TO	INITIALS/DATE FORM RECEIVED
☐ Nutrition ☐ Other	