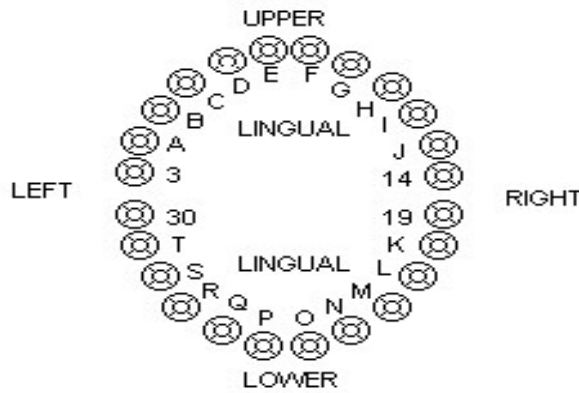


HEAD START/ EARLY HEAD START  
DENTAL EXAM – CHILD

Site: \_\_\_\_\_ Class/HV: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F

**ORAL CONDITIONS**



**Key:** Missing Decayed Filled

**PREVENTIVE SERVICES**  Cleaning/Fluoride  Varnish/Sealants (at least at 18 months)

**DENTAL SERVICES (CHECK ALL THAT APPLY)**

No Problems, **Date of Dental Exam:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Routine Recall Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Treatment Needed (Please list): \_\_\_\_\_

Approximate Number of Visits: \_\_\_\_\_

Treatment Complete

**Clinic:** \_\_\_\_\_ **Provider:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date

## HEAD START DENTAL EXAM INSTRUCTIONS

Performance Standards 1304.20 (a) (II), 1304.20 (a) (iv) (C) (2, 3)

This form is to be completed by the child's dentist with follow-up as needed. If an appointment is scheduled after the anticipated enrollment date, obtain a copy of the appointment card. The original is maintained in the child's health file.

- Dental Follow-up and Treatment Completion – This is any additional information or follow-up to the dental exam. For dental follow-up, send the Dental Exam for to be completed.