CHILD ORAL HEALTH ASSESSMENT

Date Exam Completed: ____/____/____ Child's Name: _____

Head Start Center: _____ Phone Number: _____

Address: _____

Completed by: Medical Provider's Name: _____
(Please Print)

Address: _____

Services Provided:

☐ Cleaning ☐ Fluoride Treatment ☐ Other: Specify:_____

Dental Needs:

☐ No Needs ☐ Fluoride Supplements ☐ Oral Hygiene Instruments

☐ Treatment Needed: Specify:_____

_____

_____

Approximate number of visits needed for treatment_____

Referral:

To:_____

Reason:_____

_____

Next Appointment:_____

Provider's Signature: _____ Date: ____/____/____

Date Sent _____ Classroom _____
Date Received _____

Butler County Children's Center, Inc.
Phone: 724-287-2761
Fax: 724-287-4205