Toledo Public Schools
Early Childhood Education

Phone: 419-671-_____ Fax: 419-671-_____

Dental Form

Office Use Only Peer ____ EH ____

Teacher _____

School _____

AM PM

Ohio Administrative Code 5101:2-12-37 requires that this exam be given no more than twelve months prior to the date of admission to Toledo Public Schools Early Childhood Program.

Child Name: _____ Date of Birth: _____/_____/_____

Dental Exam Visit:

Exam Date: _____/_____/_____

Received: ☐Cleaning ☐Fluoride ☐X-rays ☐Oral Hygiene Instruction

According to services rendered as of the date above, the following has been determined:

☐NO Restorations needed at this time. Next six-month check-up is _____.

☐Needs restorations, extractions, etc. but not begun at this visit.

Treatment plan: Number of teeth that need treatment*: _____

Number of visits needed: _____

Scheduled Appointment date(s)/times(s): _____

☐Our office referred child to: _____

* Note: Early Childhood Education staff will use the number of teeth needing treatment and appointment information to assist parents in understanding the importance of receiving treatment.

Dental Treatment Visit: **To be completed when treatment occurs.**

TREATMENT VISIT(S): DATE(S): _____

☐Some restorative, crowns, extractions, treatment received, but not all necessary treatment completed.

Number of teeth still needing treatment*: _____

Scheduled Appointment date(s)/time(s): _____

☐All restorative treatment completed at this visit.

_____ **Printed Dentist Name:** _____

DENTIST SIGNATURE ***** Date of examination**

Address: _____

Phone: _____ **Fax:** _____