Site/Class#: _____

Volunteers of America
GREATER LOS ANGELES

Early Head Start/Head Start/State Preschool
DENTAL EXAM FORM

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

You are authorized to release to Volunteers of America Head Start/Early Head Start information regarding this health care visit for the above named student including diagnosis and treatment.
Parent Signature:_____ **Date:**_____

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 YES NO
(including Fluoride &/or Anticipatory Guidance)

DESCRIBE PREVENTIVE CARE:

DENTAL DIAGNOSIS

Dental Diagnosis:

Number of Cavities: _____ **Early Childhood Caries/Baby Bottle Tooth Decay: YES NO**

Other Diagnosis:

DENTAL TREATMENT

Dental Treatment Initiated: YES NO **Has all Dental Treatment Been Completed?** YES NO

Describe Dental Treatment

NEXT DENTAL EXAMINATION

Date of Next Visit to complete CURRENT treatment:
Date Next Routine Dental Examination :

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

	Initials / Date Form Received:

Revised by S.L. 12/16