## OHIO DEPARTMENT OF EDUCATION DIVISION OF EARLY CHILDHOOD EDUCATION

## **DENTAL FORM**

/ Female

Male

Date of Birth:			
Parent(s)/Guardian Name:			
1 le the child new receiving an	of the following? If "	voo" include length of time r	acciving fluorida
<ol> <li>Is the child now receiving any Topical fluoride applic</li> </ol>		yes , include length of time re Unknown	Yes
Fluoridated water	No	Unknown	res Yes
Fluoride supplement		Unknown	Yes
			<u> </u>
<ol><li>Does the child have any of th</li></ol>			
Allergies	Yes	No	
Asthma	Yes	No	
Bleeding	Yes	No	
Diabetes	Yes	No	
Epilepsy	Yes	No	
Heat/Vascular diseas	eYes	No	
Liver disease	Yes	No	
Rheumatic fever	Yes	No	
Sickle cell disease	Yes	No	
Other (Please list)			
Does the child have any troub     If so, what kind?			No
4. Child has previously seen a d	entist?Yes	No	
5. Child is under a physician's ca	are?Yes	No	
6. Child is receiving medication?	YesYes	No	
<ul> <li>Extraction of non-rest</li> </ul>	or infection Ilp therapy of decayed orable teeth	ERVICES REQUIRED (on be primary and permanent teet are oral hygiene procedures.	,
Dentist or Physician Signature	st or Physician Signature Signature Date:		Pate:
-			
Dentist/Physician Name Printed			
Dentistritysician Name Philed			
Complete Address			

This is a SAMPLE FORM provided by the Ohio Department of Education that may be used to comply with the Head Start Performance Standards regarding dental examination and data (45 CFR 1304.3-3,4,5). The annual dental exam by a dentist is an oral diagnostic procedure which should include radiographs (x-rays) only if the dentist determines that they are absolutely necessary. This should be completed within 90 days of the child's entrance into the program. Developmental dental history should be part of health screening completed within 45 days of entrance.

Phone

Name of Child: