Childcare Learning Centers
Proof of Dental Exam form

To be completed by the Parent (Please Print)

Child's Name: Last First Middle	Birthdate: Month/ Day/Year
Address: Street City Zip Code	Home Telephone Number:
Center Name:	Class:
Parent or Guardian's Name	Child's Gender: Male Female

To be Completed by the Dentist:

Oral Health Status (check all that apply)

( ) Yes ( ) No Dental Sealants Present

( ) Yes ( ) No Caries Experience/ Restoration History—a filling or a tooth missing because it was extracted for carries or missing permanent 1st molars

( ) Yes ( ) No Untreated Caries

( ) Yes ( ) No Soft Tissue Pathology

( ) Yes ( ) No Other, please specify: _____

( ) Yes ( ) No Child received cleaning and prophylactic fluoride treatment in the past 6 months

Treatment Needs (check all that apply)

( ) Urgent Treatment: abscess, nerve exposure, advanced disease or pain, infection or swelling

( ) Restorative care: amalgams, composites, crowns

( ) Preventative Care: Sealants, fluoride treatment, prophylaxis

( ) Other, please specify: _____

Date of Next Appointment: _____

Signature of Dentist:_____ **Date of exam:**_____

Address: _____ **Telephone number:**_____