PICAYUNE SCHOOL DISTRICT
EARLY HEAD START/HEAD START

Dental Examination

PSD
Head Start /
Early Head Start
Whatever It Takes...
Our Kids Are Worth It!

CHILD'S NAME:_____ SEX_____ BIRTH DATE:___/___/___

DATE OF SERVICE:_____ ALLERGIES: _____

_____

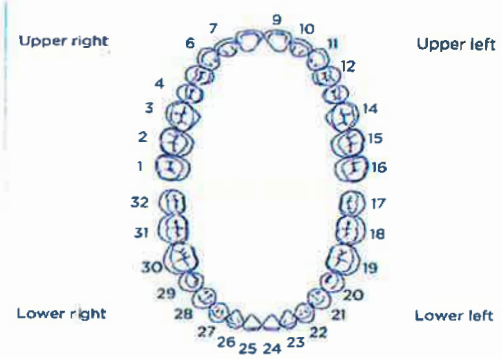
Diagnostic and Dental Needs:

☐Fluoride application

Examination Recommendation(s):

☐ No further treatment recommended at this time. Return in _____ months for an examination.

☐ Additional dental treatment is required. Treatment plan is identified below.



Tooth #	Description of work	Date of Services

Dentist Name (please print)_____

Signature _____ Phone#_____