DENTAL HEALTH APPRAISAL – YOUNG FIVES / KINDERGARTEN ONLY

STUDENT'S NAME_____

DATE OF BIRTH_____

PARENT'S NAME_____

HOME ADDRESS_____

GRADE_____ SCHOOL BUILDING_____

Doctor, please check the appropriate boxes and instruct the parent to return this form to school.

☐ I have completed an Oral Examination and find no dental attention necessary at this time.

☐ This student is still under treatment.

☐ I have completed the necessary dental treatment for this student.

☐ Dental treatment is necessary but complete examination and treatments are not yet scheduled.

☐ Are there any oral defects that may aggravate:

Speech defect: ☐ No
☐ Yes If so, state:_____

Oral hygiene: ☐ Good ☐ Fair ☐ Poor

Recommendations _____

_____

_____

_____

_____DDS _____
Signature Date