thrivALASKA
Healthy families. Thriving children.

# Head Start Birth to Five
# Verification of Dental Exam

This is to certify that _____ DOB_____
Child's Name

Is one of my patients and was seen for an exam on _____.
Examination Date

The following applies to this patient:

☐ Needs **no treatment** at this time

☐ Needs **routine examination** in the month of _____

☐ Needs the **following services/follow-up treatment:**
_____

☐ The patient was **unable to be examined** due to _____

☐ An appointment is scheduled for _____

**During this visit the following services were performed:**

| Tooth letter and surface | Description of work | Comments | Other Services | Educational Needs |
|---|---|---|---|---|
| | | | Exam: Y N | Oral Hygiene: Y N |
| | | | Chair ride: Y N | Dietary Concerns: Y N |
| | | | Fluoride Y N | Routine Visits: Y N |
| | | | X-Rays: Y N | Infant Dental Caries: Y N |
| | | | Prophy: Y N | Other: |
| | | | Other: | |

During this dental visit, did the child receive fluoride supplements? ◯ Yes ◯ No

**Notes:**_____

_____

Additional Notes/Dentist Recommendations: _____

_____

**Dentist Signature (REQUIRED):** _____ Phone/Fax: _____

Clinic Name:_____ Address: _____

**I give permission for the most recent dental exam to be faxed to Thrivalaska Birth to Five Head Start Attn: Health and Safety, at 452-4203.**

Parent Signature:_____Date:_____

Form received _____(staff initials) date
Revised 7/12

Entered in CP _____(HSC initials) date
Performance Standard Section Health and Safety 1304