School Health Record
Summit County Health District

School _____

Child's Name	Birth date

Parent / Guardian	Home phone number

Dentist's Report

The following services have been performed:

- □ Examination
- □ Radiographs
- □ Prescription for fluoride supplements
- □ Diagnosis
- □ Oral prophylaxis
- □ Topical application of fluoride

The following oral hygiene instruction was provided:

- □ Tooth brushing
- □ Diet counseling reflecting relation of diet to dental health
- □ Flossing
- □ Home/school use of fluoride mouth rinse

The following statements are applicable:

- □ All necessary services have been performed
- □ Further treatment is indicated
- □ No restorative services are required at this time
- □ Further appointments have been arranged

Comments: _____

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Please Print or Stamp:

Dentist's name	Dentist's signature
Address	Date signed
Phone	