

MODIFIED SCHOOL HEALTH PROGRAM (FAMILY DENTIST REPORT)

NAME OF CHILD	(Last)	(First)	(Middle)	BIRTHDATE	HOMEROOM
HOME ADDRESS	(No. and Street)			SEX	
				M <input type="checkbox"/>	F <input type="checkbox"/>

THE ABOVE NAMED CHILD LAST VISITED MY OFFICE ON _____ (GIVE DATE). AT THAT TIME ALL NECESSARY DENTAL CORRECTIONS HAD BEEN MADE. YES NO

IF THE ANSWER IS NO, FILL IN THE FOLLOWING:

THIS CHILD IS IN NEED OF TREATMENT FOR ONE OR MORE OF THE FOLLOWING:

- PRIMARY TEETH _____ FILLINGS EXTRACTIONS
 PERMANENT TEETH _____ FILLINGS EXTRACTIONS
 DISEASES OF THE SUPPORTING TISSUES _____
 GROSS MALOCCLUSION WHICH IS PRODUCING A FACIAL DEFORMITY OR IS INTERFERING
 WITH FUNCTION
 CLEFT PALATE AND/OR CLEFT LIP OTHER CONGENITAL MALFORMATIONS
 PROSTHETIC REPLACEMENTS FOR LOST OR MISSING TEETH _____
 THIS CHILD IS CURRENTLY UNDER TREATMENT _____ YES NO

SIGNATURE _____ D.D.S.

DATE SUBMITTED _____ ADDRESS _____

SOURCE: School Health Services

DATE: October 18, 1976