Head Start Dental Exam Form H-3

PLEASE FILL OUT FORM COMPLETELY AND MAIL OR FAX TO:

Pocatello Head Start 330 Oakwood Dr., Pocatello, ID 83204 Fax (208)232-4906

CHILD'S NAME:_____________________________SEX_______BIRTH DATE:__________

ACTUAL DATE OF EXAM_____________ Type of exam: Screening ◯ Assessment ◯

PLEASE PRINT DENTIST NAME____

GUM CONDITION: (Check one)

- **Normal** ☐
- **Swollen** ☐
- **Bleeds easily** ☐
- **Infected** ☐

DENTAL NEEDS: (Check one)

- **No Needs** ☐
- **Needs Treatment** ☐

Approximate number of visits________

Additional Comments:

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***Must have the Dentist signature and Actual Date of Exam per Federal Guidelines.**

Signature____ Date_____________________

PLEASE MAIL OR FAX
WITHIN 7 DAYS
OF EXAM

White copy: Send to Head Start **Yellow copy:** Retain for dental records 2-05