NAME _____ BIRTH DATE _____ SCHOOL _____

OHIO SCHOOL HEALTH RECORD
DENTIST'S REPORT

The following services have been performed:

_____ Examinations

_____ Diagnosis

_____ Radiographs

_____ Oral prophylaxis

_____ Prescription for fluoride supplements

_____ Topical application of fluoride

The following oral hygiene instruction was provided:

_____ Tooth brushing

_____ Flossing

_____ Diet counseling reflecting relation of diet to dental health

_____ Home/school use of fluoride mouth rinse

The following statements are applicable:

_____ All necessary services have been performed

_____ No restorative services are required at this time

_____ Further treatment is indicated

_____ Further appointments have been arranged

COMMENTS: _____

_____

_____

PLEASE PRINT OR STAMP

Dentist's Name: _____

Address _____ City _____ State _____ Zip _____

Phone ( ) _____

Dentist's Signature _____ Date Signed _____

This form should be turned in at the school office no later than the second week of classes.