Olympic Educational Service District 114
105 National Avenue North, Bremerton, Washington 98312
(360) 478-6887 ● 1-800-201-1300 ● FAX (360) 405-5808

DENTAL EXAM

OESD 114 Head Start/Early Head Start/ECEAP

Attention: _____

Child Name: _____ **DOB:** _____

I give my permission for a mutual exchange of information between my child's dental provider _____ at (clinic name) _____ and OESD 114 Head Start/Early Head Start/ECEAP concerning my child's oral health status. Information may be exchanged via fax, or land mail.

Parent/Guardian Signature **Date**

PLEASE DO NOT SEND A COPY OF CHILD'S DENTAL RECORD. COMPLETE THIS FORM ONLY.

Exam Date: _____ Next Exam/Recall Due _____

Are you serving as this child's primary dental provider?

_____ Yes
_____ No

Is this child up to date on a schedule of age appropriate preventative and primary dental care?

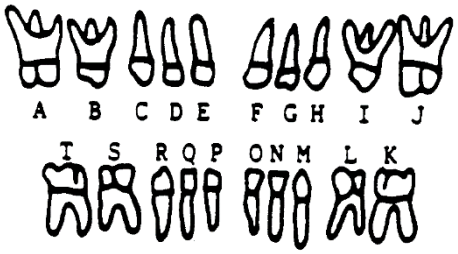
_____ Yes
_____ No

Were preventative services provided to this child?

_____ Yes
_____ No

Fluoride prescribed?

_____ Yes
_____ No
_____ In local water source



Does this child need treatment?

_____ NONE
_____ Restorations
_____ Pulp Therapy
_____ Extractions

Sealants

_____ Not recommended
_____ Recommended
_____ Received

Treatment Follow Up:

_____ Treatment completed on
_____ Referred to
_____ Treatment scheduled on

Provider Comments: _____

Signature of Provider _____ **Date** _____

THANK YOU FOR YOUR WORK WITH YOUNG CHILDREN