Whitehall City Schools Health Record
Dentist's Report

Child's Name:	**☐ Male ☐ Female**	**Age**	**Date**

Dental Services

The following services have been performed:		
☐ Examination	☐ Radiographs	☐ Prescription for fluoride supplements
☐ Diagnosis	☐ Oral prophylaxsis	☐ Topical application of fluoride

Oral Hygiene

The following oral hygiene instruction was provided:	
☐ Toothbrushing	☐ Diet counseling reflecting relation of diet to dental health
☐ Flossing	☐ Home/school use of fluoride mouthrinse

Dentist's Assessment

Please check all that apply:	
☐ All necessary services have been performed	☐ Further treatment is indicated
☐ No restorative services are required at this time	☐ Further appointments have been arranged

Additional information that would aid the school in helping the child be successful.

_____
_____
_____
_____

Please Print or Stamp

Dentist's Name:	Dentist's Signature:
Address:	Date Signed:
	Phone Number:

Thank you for your assistance in completing this form.
Whitehall City Schools