Please fill in each section of this form including the status of treatment information and treatment appointment date if applicable.

Palmdale School District
Early childhood Education
975 E. Ave P-8 Palmdale, Ca 93550
Office (661) 273-4710 Fax (661) 273-1037

Site:
Classroom:

Early Childhood Education Dental Exam

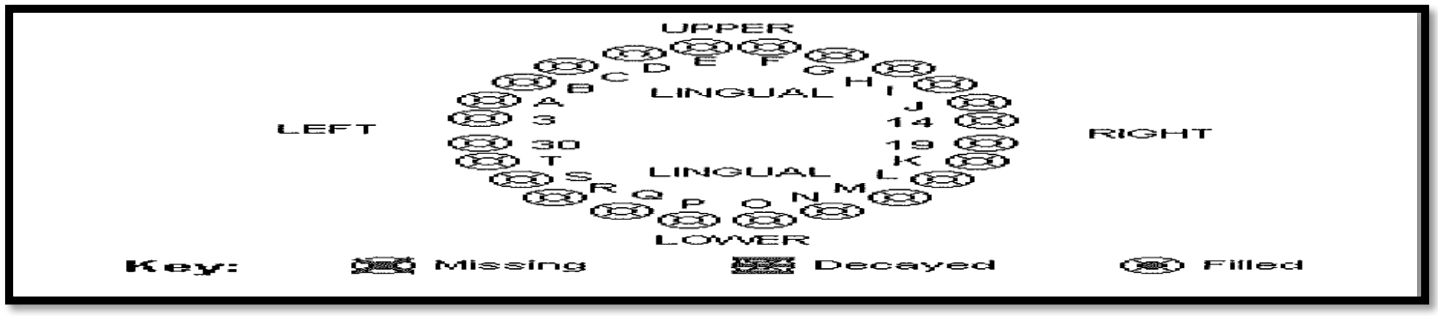
(Please fill out each section of this form)

Child's Name:	**Date of Birth:**	**Gender:** ____ M _____ F
Dental Insurance Type: □ Medi-cal □ Private □ None		

AUTHORIZATION FOR RELEASE OF INFORMATION

You are authorized to release to Palmdale School District Early Childhood Education information regarding this health care visit for the above named child including diagnosis and treatment.

Name of Parent or Guardian:_____
Telephone:_____
Parent Signature:_____ **Date:**_____
Type of Health Coverage (if none please indicate):_____



Date of Exam:	**Services:** □ Cleaning □ X-rays □ Fluoride □ Fillings □ Prophylaxis □ Follow-up Treatment □ Parent provided with education about oral health		
Priority Criteria:	□ Immediate Care □ Extensive Decay Number of Cavities _____	☐ No Cavities	☐ Possible, Observing until: _____
Dental Needs Identified:	□ Early Childhood Caries □ Baby Bottle Syndrome		
Results :	□ Routine recall visits in 6 months □ Treatment Initiated □Treatment Needed □ Treatment Completed □ Referred to Specialist		
Next Scheduled Appointment Date:			
Recommended Follow-up Care: ***(please include treatment timeframe):***			
Dental Provider Signature and/or Stamp:		**Date:**	

FOR HEAD START STAFF ONLY

Signature of staff completing review:	**Position:**	**Date:**
☐ **Nutrition Referral**		**Initial/Date received**