Los Angeles County Office of Education
Serving Students ▪ Supporting Communities ▪ Leading Educators

Head Start - State Preschool

DENTAL EXAM FORM

LAST NAME, FIRST NAME, MIDDLE INITIAL	SEX ☐ M ☐ F	DATE OF BIRTH	NAME OF PARENT OR GUARDIAN

DELEGATE AGENCY NAME	SITE NAME

TO BE COMPLETED BY DENTIST

DENTAL EXAMINATION ADMINISTERED BY (TYPE OR PRINT NAME)

SIGNATURE	TELEPHONE NUMBER

ADDRESS

DENTAL SERVICES PROVIDED

DATE OF EXAM

Diagnostic/Preventive Services	Yes	No
Examination		
X-rays		
Risk Assessment		
Cleaning		
Flouride Varnish		
Dental Sealants		

Counseling/Anticipatory Guidance
☐ Yes ☐ No

Referral to Specialty Care
☐ Yes ☐ No

PLEASE SPECIFY SPECIALIST

DENTAL DIAGNOSIS

	Yes	No
Normal Examination - No Treatment Needed		
Dental Treatment Needed		
Cavities		
Early Childhood Caries		
Gum Disease		

Additional Comments/Other Diagnosis:

Number of Cavities

DENTAL TREATMENT IF APPLICABLE

	Yes	No
Dental Treatment Initiated		
All Treatment Completed		
DATE OF NEXT TREATMENT VISIT		

Treatment/Restrictions/Recommendations for School

NEXT DENTAL EXAMINATION

6 Months	12 Months	Other (Please Explain)
☐	☐	☐

TO BE COMPLETED BY HEAD START STAFF

SIGNATURE OF STAFF COMPLETING 1ST REVIEW (45 DAYS)	POSITION	DATE
SIGNATURE OF STAFF COMPLETING 2ND REVIEW (90 DAYS)	POSITION	DATE

HEAD START FOLLOW-UP

REFERRED FOR FOLLOW-UP TO	RECEIVED BY (PRINT NAME)	DATE RECEIVED
☐ Nutrition ☐ Family Servicecs ☐ Other		