SANTA ANA UNIFIED SCHOOL DISTRICT
Early Childhood Education Program

SITE _____
1629 S. Center St.
Santa Ana, CA 92704

REQUIRED DENTAL EXAMINATION FORM

Name of Child _____ Date of Birth _____

Dental Insurance _____

Name of Parent(s) _____ Phone number _____

To the Dentist

The above named child is participating in the Early Childhood Education program and is required to submit evidence of a dental examination performed within the last six months. After the examination results are recorded, please return the completed form to the parent.

DATE OF EXAM_____ **DATE OF NEXT APPOINTMENT IF REQUIRED**_____

	Please Indicate All Applicable Statements	Check Below
1	X-Rays, Examination and Diagnosis, Prophylaxis and Topical Fluoride	
2	No Treatment needed	
3	Surface Filling (number needed)	
4	Stainless Steel Crown (number needed)	
5	Pulpotomy (number needed)	
6	Extraction (number needed)	
7	Other (specify)	

Status of Treatment

__ Completed __ Not Completed *Explain*: _____

Name of Dentist _____ Date _____

Dentist's Address: _____

Dentist Stamp Here

Dentist's Signature _____

Dentist's Phone number _____

White Copy = Child's File Yellow Copy = Parent

03/10
Tab#4