



**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 \_\_\_\_\_

	<b>Please Indicate All Applicable Statements</b>	<b>Check Below</b>
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 \_\_\_\_\_

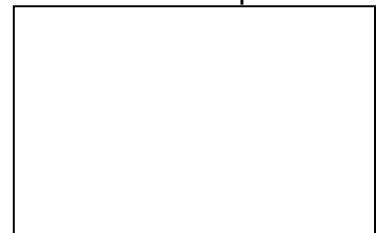
Date \_\_\_\_\_

Dentist's Address: \_\_\_\_\_

Dentist's Signature \_\_\_\_\_

Dentist's Phone number \_\_\_\_\_

Dentist Stamp Here



White Copy = Child's File

Yellow Copy = Parent