OHIO SCHOOL HEALTH RECORD/DENTIST REPORT

Child's Name_____ **Sex M___ F___**

Date of Birth_____

Exam Date_____

The following services have been preformed:

__Examination __Radiographs __Prescription for Fluoride

__Diagnosis __Oral Prophylaxis __Topical Application of Fluoride

The following oral hygiene instruction was provided:

__Tooth brushing __Diet Counseling

__Flossing __Use of Fluoride mouth rinse

The following statements are applicable:

__ All necessary services have been preformed

__No restorative services are required at this time

__Further treatment is indicated

__Further appointments have been arranged

Comments:

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Dentist's Name_____ Dentist's Signature_____

Address_____ Phone_____