ROCKY MOUNTAIN DEVELOPMENT COUNCIL, INC. (ROCKY)
HEAD START
DENTAL EXAM

Child's name: _____ Date of Birth: _____

Parent(s)/Guardian: _____

Head Start requires that all children have a yearly dental exam and that recommended treatment be completed, as dental problems and tooth pain can affect a child's ability to learn.

DENTAL REPORT

Date of exam: _____ Name of Dentist (printed): _____

_____ This child was examined; there were NO dental problems. Regular six month checkups were encouraged.

_____ Cleaning and preventative Fluoride Treatment were completed.

_____ This child needs dental treatment for_____

_____ This child has SEVERE dental problems and needs immediate care.

_____ Follow up appointments for treatment have been scheduled for_____
(Date)

_____ Next checkup scheduled for _____
(Date)

_____ _____
(Signature of Dentist) (Date)

Exam reports can be faxed to: (406) 447-1629, Attn: Health Manager, Head Start.