Frederick County Health Department* and *Frederick County Public Schools
DENTAL HEALTH REPORT

Student Name: _____ **Date of Birth:** _____

Address: _____ **Grade:** _____

_____ **School:** _____

To be completed by the Dental Provider

I. Oral Health Status (check all that apply)	***II. Treatment Needs (check all that apply)***
☐ **Yes** ☐ **No** Dental home established	☐ **Urgent Treatment:** abscess, nerve exposure, advanced disease state, signs/symptoms of pain, infection or swelling
☐ **Yes** ☐ **No** Untreated caries	☐ **Restorative Care:** amalgams, composites, crowns, etc.
☐ **Yes** ☐ **No** Soft tissue pathology present	☐ **Preventive Care:** sealants, fluoride treatment, prophylaxis
☐ **Yes** ☐ **No** Malocclusion	☐ **Other:** periodontal, orthodontic.
☐ **Yes** ☐ **No** Are any restorations or space maintainers present in the child's dentition?	*Comments:* _____
☐ **Yes** ☐ **No** Frequent snacking on cariogenic foods	
☐ **Yes** ☐ **No** Frequent juice/soda consumption	
☐ **Yes** ☐ **No** Dental sealant(s) present	
Caries Risk Assessment: ☐ **High** ☐ **Moderate** ☐ **Low**	***Date of Examination:*** ____/____/____

_____ _____ _____
Parent/Guardian Signature *Phone* *Date*

_____ _____ _____
Dental Provider Signature *Phone* *Date*

_____ _____
Printed Name *Address*

Please return this form to the SCHOOL HEALTH ROOM