Classroom Dental Examination Form

Head Start Center _____

Child's Name _____ Sex ___ Birth Date _____

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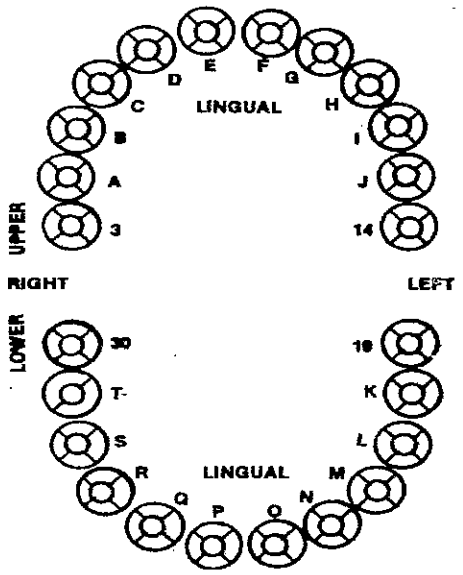

Red=Decayed

Blue=Filled

Priority Group

____ A. Needs Attention Immediately

____ B. Needs Attention Soon

____ C. Needs Routine Care

Additional Comments _____

_____

_____

_____

_____

_____

_____

Results of Examination

___ This child is referred for further dental examination and/or treatment

___ This child does not need dental treatment at this time

___ This child cannot be examined at this time

Dental Examiner's Signature _____

Date of Examination _____