# BALTIMORE COUNTY DEPARTMENT OF HEALTH

Division of School Health

## SCHOOL DENTAL HEALTH RECORD

NAME OF STUDENT :_____________________________________________ DATE:______________

NAME OF SCHOOL:_______________________________________________ AGE:_______________

SCHOOL NURSE: ________________________________________________ GRADE:____________

Please take this form to your family dentist when your child has his/her next dental appointment.
Have your dentist complete the form and have your child return the form to the school nurse.

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REPORT OF DENTAL EXAMINATION:

A. ❑ No dental treatment is necessary

B. ❑ All necessary dental treatment has been completed

C. ❑ Treatment is in progress

FURTHER RECOMMENDATIONS:_____________________________________________________________

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_____________________________________________________________________________________

_____________________________________________ ______________________________

Signature of Dentist Date

_____________________________________________

Name (Please print or type)

_____________________________________________

Address

_____________________________________________

PHONE:_____________________________________

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