

Ohio School Health Record
Dentist's Report

Student Name: _____ Grade: _____

The following services have been performed:

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> Examination | <input type="checkbox"/> Radiographs | <input type="checkbox"/> Prescription for fluoride supplements |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Oral Prophylaxis | <input type="checkbox"/> Topical application of fluoride |
-

The following oral hygiene instruction was provided:

- | | |
|---|---|
| <input type="checkbox"/> Tooth-brushing | <input type="checkbox"/> Diet counseling reflecting relation of diet to dental health |
| <input type="checkbox"/> Flossing | <input type="checkbox"/> Home / School use of fluoride mouth rinse |
-

The following statements are applicable:

- | | |
|--|--|
| <input type="checkbox"/> All necessary services have been performed | <input type="checkbox"/> Further treatment is indicated |
| <input type="checkbox"/> No restorative services are required at this time | <input type="checkbox"/> Further appts. have been arranged |
-

Comments: _____

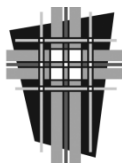
PLEASE PRINT OR STAMP

Dentist's Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Dentist's Signature: _____ Date: _____



ST. ANTHONY
SCHOOL