WASHTENAW COUNTY HEAD START
DENTAL RECORD

Head Start Location: ____ **Program Year:** _______________

Child's Name: ____________________________________ **Gender:** _______ **Date of Birth:** ________________

PART I Health Information and Previous Dental Experience

1. **CHILD (___ HAS ___ HAS NOT) PREVIOUSLY SEEN A DENTIST.** 2. **CHILD (____IS ____ IS NOT) UNDER A PHYSICIAN'S CARE.** 3. **CHILD (____ IS ____ IS NOT) RECEIVING MEDICATION.**	4. **CHILD IS REPORTED TO HAVE** (give details or attach Health History) Yes No / Yes No Allergies _____ _____ Liver Disease ____ ____ Asthma _____ _____ Rheumatic Fever ____ ____ Bleeding _____ _____ Sickle Cell Disease ____ ____ Diabetes _____ _____ Other (List Below) ____ ____ Epilepsy _____ _____ ___________________________ Heart/Vascular Dis. _____ _____ ___________________________

PART II Examination and Treatment Record

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Date Services Performed Month Day Year	Tooth # or Letter	Surfaces	Procedure/ treatment

PART III Evaluation of Child's Oral Health

CHILD ORAL HEALTH SUMMARY

All planned treatment (____ is, ____ is not) complete. If not, explain: ____

____

____

Referral to: ____

Dentist's Name (Please print): ___________________________________

Dental Practice Name____

_____________________________________ _______________

Dentist's Signature Date

My staff and or I am/ are interested in learning how I/we can become involved in the Head Start Program YES NO

Revised 1/09