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 you child has his next dental appointment. Have your dentist complete the form and have your child return the form to the school nurse.

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: _____

_____

_____

_____

_____ Date: _____
Signature of Dentist

_____
Please type or print Name of Dentist

_____
Address

_____

Phone: _____

SH-4: 9/99