

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 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: _____

Signature of Dentist _____ Date: _____

Please type or print Name of Dentist _____

Address _____

Phone: _____