Akron Children's Hospital
School Health Services

Dentist Report
(to be completed by the Dentist)

Child's Name _____ **Age:** _____

The following services have been performed:

_____ Examination _____ Radiographs _____ Prescription for fluoride supplements

_____ Diagnosis _____ Oral prophylaxis _____ Topical application of fluoride

The following oral hygiene instruction was provided:

_____ Toothbrushing _____ Diet counseling

_____ Flossing _____ Home/school use of fluoride mouth rinse

The following statements are applicable:

_____ All necessary services have been performed _____ Further treatment is indicated

_____ No restorative services are required at this time _____ Further appointments have been arranged

Comments: _____
_____
_____
_____

Please Print or Stamp:

Dentist's Name	**Signature:**
Address:	**Date Signed:**
Phone:	

Revised 1/11