THE SCHOOL DISTRICT OF PHILADELPHIA
OFFICE OF EARLY CHILDHOOD EDUCATION
440 N. BROAD STREET
PHILADELPHIA, PA 19130-4015

#10: CHILD DENTAL HEALTH/DENTAL EXAM FORM

Child's Name _____ Date of Birth _____

SECTION 1: Completed by parent/guardian

1. Has your child been to the dentist? ☐ No ☐ Yes – if 'Yes', date of child's last dental visit _____
2. Does your child have (or had) cavities or caries? ☐ No ☐ Yes – If 'Yes', how many? _____
3. Does your child have any problems with his/her teeth, gums, or mouth? ☐ No ☐ Yes
   If 'Yes', please describe _____
4. How many times a day does your child brush his/her teeth? _____

SECTION 2: Completed by child's Dentist

1. Date of child's most recent:
   Dental Examination _____ Teeth Cleaning _____ Fluoride Treatment _____
2. Has child ever needed dental treatment? ☐ No ☐ Yes
   If Yes, type of dental treatment _____
   Has dental treatment been completed? ☐ No ☐ Yes – if 'Yes', date of completion _____
3. Date of child's next dental visit _____

My signature certifies the accuracy of this information.

Dentist's Signature _____

Date _____

Dental Office Stamp

_____