Sacramento City Unified School District
CHILD DEVELOPMENT DEPARTMENT

PRESCHOOL DENTAL HEALTH / EXAM RECORD

Child's Name: ____ Birthdate: _______________ M___ F___

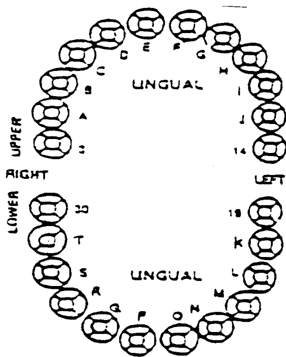
Parent/Guardian Name: ______________________________________ Phone: ___________________________

Address: ____

I authorize professionally qualified people to exchange information about my child. I understand that all information will be kept in a confidential file.

Parent/Guardian Signature: _____________________________________ Date: _______________

DENTAL PROVIDER:



PLEASE LIST ALL SERVICES PROVIDED BELOW AND COMPLETE SUMMARY:

Date of Service	Tooth # or Letter	Description of Services Provided

SUMMARY:

- ☐ No Cavities/ No Treatment Needed
- ☐ Preventive: Prophy/Fluoride Varnish
- ☐ Specialist Referral Given __________
- ☐ Dental Treatment Completed
- ☐ Approx. # of visits needed ______
- Next Appointment Date __________

Dentist: ________________________ ______________________________ ________________________
(Please print) (Signature) (Date)

Address:____ Phone: (_____)___________

If treatment is not complete at this visit, please fill out a new form for each additional visit until treatment is completed.
Please return completed forms to:

Child Development Department
Hiram Johnson Family Education Center
3535 65TH Street, Sacramento, CA 95820
(916) 395-5500 **Fax: (916) 277-6698**

For SCUSD Nurse Use Only:

- ☐ Dental Exam ☐ Pass/☐ Fail
- ☐ Preventive: Prophy/Fluoride Varnish
- ☐ Dates of Treatment: _______________
  - ☐ Treatment In-Process
  - ☐ No Treatment Needed
  - ☐ Treatment Completed
- ☐ Approx. # of Visits Needed: _________
- ☐ Referred to Specialist: ______________