Sacramento City Unified School District
CHILD DEVELOPMENT DEPARTMENT

PRESCHOOL DENTAL HEALTH / EXAM RECORD

Child's Name: _____ Birthdate: _____ M___ F___

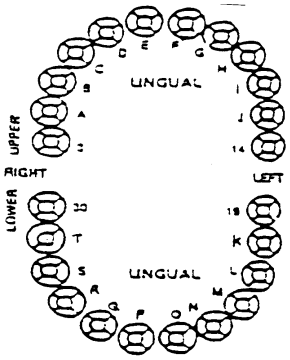
Parent/Guardian Name: _____ Phone: _____

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 Treatment Needed
- ☐ Preventive Care Given
- ☐ Specialist Referral Given _____
- ☐ Dental Treatment Received
- ☐ 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: (PLEASE CHECK ONE)

☐ Child Development Department
Capital City Registration Center
7220 - 24th Street, Sacramento, CA 95822
(916) 433-2736 **Fax: (916) 433-2738**

☐ Child Development Department
Hiram Johnson Family Education Center
3535 65TH Street, Sacramento, CA 95820
(916) 277-7151 **Fax: (916) 277-6698**

For SCUSD Nurse Use Only:

- ☐ Dental Exam ☐ Pass/☐ Fail
- ☐ Preventive Dental Care Given
- ☐ Treatment given: _____
  - ☐ Treatment In-Process
  - ☐ Treatment Completed
- ☐ Approx. # of Visits Needed: _____
- ☐ Referred to Specialist: _____

Data Entry (initials/date): _____