Stanislaus County Office of Education
Tom Changnon, Superintendent

Child & Family Services

Tony Jordan, Executive Director
1100 H Street • Modesto CA 95354 • (209) 238-1800 • FAX (209) 238-4217

CHILD/FAMILY SERVICES
DENTAL CARE REPORT

Head Start Facility: _____ Date: _____

Child's Name _____
Last First Birthdate

PARENT AUTHORIZATION: I hereby give my consent for the dentist named below to send a dental care report to Head Start designated health staff.
AUTHORIZACIÓN DEL PADRE: Yo, por la presente, doy mi consentimiento al dentista nombrado abajo para que mande el reporte al Programa Head Start.

Parent/Guardian Signature: _____

Designated Health Staff Signature: _____

Name of Dentist:_____

Address:_____ Phone: _____

Please complete and/ or fax to designated health staff listed above.

DENTAL CARE PROVIDED:

Date Provided

Initial examination and x-rays _____

Dental Cleaning _____

Fluoride/Varnish Applied _____

Receiving Treatment _____

Complete/No Further Treatment _____

If exam/treatment was unable to be completed, please state reason: _____

_____

Examining Dentist Signature: _____ **Exam Date:** _____

Examining Dentist Name: _____
(PRINT Dentist Name)

Distribution: White – Child's Health File; upon completion by dentist Yellow – Health File