Tree of Life
CHRISTIAN SCHOOLS

Ohio School Health Record
Dentist's Report

Student Information:

Full Name _____ _____

Address _____ _____

Birth Date _____ _____

Mother's Full Name _____ _____

Father's Full Name _____ _____

Dental Report Information:

Dentist Name _____ _____

Dentist Address _____ _____

Date of Examination _____ _____

***The following services have been performed*: (please check)**

_____Radiographs

_____Oral prophylaxis

_____Fluoride treatment

_____Restorations

The following statements are applicable: (please check)

_____ All necessary services have been performed.

_____ No restorative services are required at this time.

_____ The child is in treatment and future appointments have been arranged.

Dentist Signature_____ ***Date*** _____

(Revision 2016)