Child's Name_____

Date of Birth _____

New Name. Same Mission. Putting Families First.

child Care Resource & Referral | Families First OF MINNESOTA

Head Start/Early Head Start
**ATTENTION:** Health Services Coordinator
126 Woodlake DR SE
Rochester, MN 55904
Phone: 507.424.1532 or 1.800.462.1660
Fax number: 507.287.2411

## *A Yearly Dental Examination is a Federally Mandated Head Start Program Requirement*

| **Services** | **Date Services Completed** |
|---|---|
| **Examination/BSS** | |
| **X-Ray** (if necessary) | |
| **Preventative Services** (if necessary)<br><br>Prophylaxis (if necessary) | |
| Fluoride Treatment (if necessary) | |
| Sealants (if necessary) | |
| **Restorative Services** (if necessary) | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

*IF HEAD START will be billed for treatment, an estimate **MUST** be approved in advance!*

Please Check:
- ☐ has completed all necessary dental treatment and should return in ____months for a routine visit.
- ☐ treatment discontinued.
- ☐ fluoride prescribed and dosage level _____.
- ☐ this child needs nutrition counseling from a dental standpoint.
- ☐ my office will provide this treatment
- ☐ my office has referred the child to _____.

**Please List Future Routine or Treatment Scheduled Appointment Date(s): _____**

Comments:_____

I hereby certify that the services listed above have been performed:

Signature of Dentist/Hygienist Print Name

Address Phone