Families First of Minnesota Head Start	
Form Name: Dental Exam	**Author:** Health Coordinator
Associated Section #: Health Program Services	
Associated Part/Subpart: 1302.42(b)(1)(i)(ii)(c)(1)	

Head Start/Early Head Start
ATTENTION: Health Services Coordinator
126 Woodlake DR SE
Rochester, MN 55904
Phone: 507.287.2020 ext. 1573
Fax number: 507.287.2411

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

Child's Name: _____**Date of Birth:** _____

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

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): _____

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

Signature of Dentist/Hygienist — Print Name

Address — Phone