

**CHILD/FAMILY SERVICES
DENTAL CARE REPORT**

Initial Appointment Scheduled for _____
Date

Service Options: ___Center Based ___Home Based ___FCCH

Location _____ Date _____

Child's Name _____
Last First Phone Birthdate

Address _____
City State ZIP

PARENT AUTHORIZATION: I hereby give my consent for the dentist named below to send a dental care report to the Head Start Nurse named on this authorization.

AUTHORIZACIÓN DEL PADRE: Yo, por la presente, doy mi consentimiento al dentista nombrado abajo para que mande el reporte al Programa Head Start/Migrante Head Start/Desarrollo de Niños.

Parent/Guardian Signature: _____

Health Staff Signature: _____

TO: _____
Dentist Name

_____ Address _____ Phone _____

Please complete and return the yellow copy of this report to the above named Health staff in the self-addressed envelope provided.

DENTAL CARE PROVIDED:

	Date Provided	Reason for incomplete treatment (please check):	
Initial examination and x-rays	_____	Appointments not kept	_____
Prophylactic treatment	_____	Family moved	_____
No other care needed at this time	_____	Child uncooperative	_____
Treatment started	_____	Treatment not authorized	_____
Treatment completed	_____	Funds lacking	_____
Cost of Services Received	_____		

Examining Dentist Signature: _____ Date _____

Examining Dentist Name: _____
(PRINT Dentist Name)

Distribution: White – Dentist Yellow – Health File; upon completion by dentist Pink - Health File