MARION COUNTY SCHOOLS DENTAL FORM

Child's Name:	Date of Birth:	Gender:

Address:	Phone:

Dental Needs:

- ❑ Cleaning
- ❑ Exam
- ❑ Fluoride Treatment Received
- ❑ Sealant Administration
- ❑ No Problems Noted

Treatment Required:

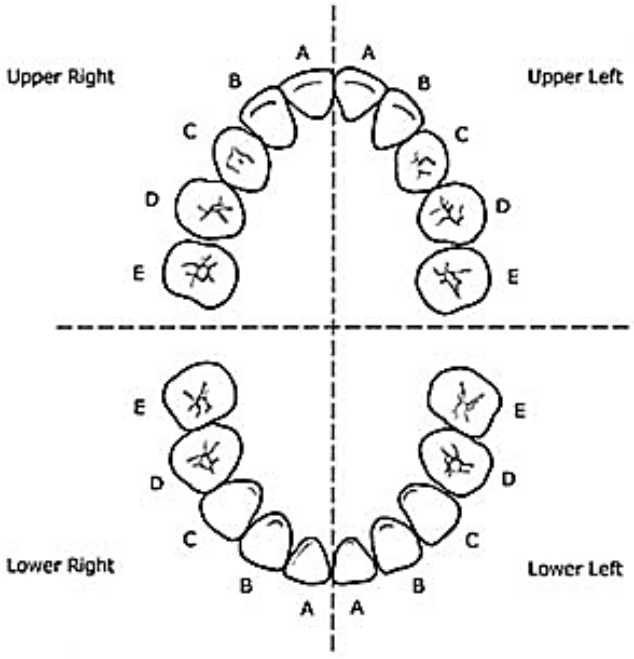
- ❑ Restoration
- ❑ Pulp Therapy
- ❑ Extraction
- ❑ Other

_____

Oral conditions prior to today's visit: ***(Please indicated on diagram all that applies)***

Missing Tooth: (X) **Decayed Tooth: (=)** **Filled Tooth: (⬬)**

DATE	TOOTH #	UR/UL LR/LL	SURFACE	DESCRIPTION OF WORK
				NEXT SCHEDULED APPOINTMENT



Provider Signature required for validation:

Date of Service: _____

Name of Clinic: _____

_____

Signature of Dental Provider

Please return this form to:
The school where child attends
or send to School Nurse's office
601 Locust Ave.
Fairmont, WV 26554
Fax: 304-366-2483