Cambridge School District
DENTAL EXAMINATION FORM

Child's Name_____Birth Date_____

Parent or Guardian_____Address_____

Dental Exam:

____ No apparent pathology. Child only in need of regular check-up and preventive dental care.

____Child needs routine treatment:
____Restorative dental care
____Treatment of gingivitis
____Care of Malocclusion
____Treatment for fractured teeth
____X-rays
_____Prophylaxis & fluoride treatment

_____Dental history and examination indicate:
___Inadequate or unbalanced diet
___Overuse of sweets

Recommendations to parent or guardian:

Recommendations to school:

Date _____

_____
Dentist's Signature

Address:
_____
_____