SEQUATCHIE VALLEY HEAD START
Verification of Dental Exam/Treatment

Name of child's dentist____

This is to certify that _________________________________**DOB**______________**is one**

of my regular patients and was last seen in my office, for an exam, on_________________.

The following applies to this patient:

- ☐ **Exam revealed no treatment needed at this time.**
- ☐ **Exam revealed treatment was needed.**
  - ☐ **Treatment was completed on** ________________________
  - ☐ **Needs the following treatment** __________________________________

    ____

    ____
- ☐ **Needs a routine examination in the month of** __________________
- ☐ **Prophylaxis was done.**

Comments:____

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Signature of Dentist_____________________________

Date_____________________________

As Parent or Legal Guardian of ___________________________**, I hereby give my**

permission for the above information to be released to the Head Start program.

Parent or Legal Guardian_________________________

Date_________________________

Original – Head Start office   Copy – Child's center record

I:users/csr/forms