St Aloysius A Tradition of Excellence
Catholic Elementary & Jr. High School

Dentist's Report
Ohio School Health Record

Date of Examination_____

Child's Name _____ _____
Last First Middle Date of Birth

The following services have been performed:

_____ Examination
_____ Diagnosis
_____ Radiographs
_____ Oral Prophylaxis
_____ Prescription for fluoride supplements
_____ Topical application of fluoride

The following oral hygiene instruction was provided:

_____ Tooth brushing
_____ Flossing
_____ Diet counseling reflecting relation of diet to dental health
_____ Home/School use of fluoride mouth rinse

The following statements are applicable:

_____ All necessary services have been performed
_____ No restorative services are required at this time
_____ Further treatment is indicated
_____ Further appointments have been arranged

Comments: _____

_____

PLEASE PRINT OR STAMP

Dentist's Name _____

Address _____

Phone_____

_____
Dentist's Signature Date Signed