WYOMING CITY SCHOOLS
HEALTH SERVICES

DENTIST'S REPORT

Child's Name: _____

Date of Birth: _____ School: _____ Grade: _____

The following services have been performed:
(please check)

_____ Radiographs

_____ Oral Prophylaxis

_____ Fluoride Treatment

_____ Restorations

The following statements are applicable:
(please check)

_____ All necessary services have been performed

_____ No restorative services are required at this time

_____ Further treatment is indicated

_____ Future appointments have been arranged

Comments:

_____ _____

DENTIST'S SIGNATURE/STAMP **DATE OF EXAM**