DRAKE UNIVERSITY HEAD START/EARLY HEAD START/EHS-CCP

DENTAL EXAM – Birth to 5 years

3800 Merle Hay Rd., Suite 323, Des Moines, IA 50310, Fax: 515-635-0716

Child's Name: _____ **Program:** _____

Dental Office Name: _____

Address: _____ **Phone:** _____

Has this child had previous dental care? Yes No

SERVICES PROVIDED:

Month	Day	Year	Description of Work

DRAKE UNIVERSITY HEAD START REQUIRES THE CHILD BE SEEN BY A <u>DENTIST!</u>

Needs to return for: Urgent Care _____ Appointment Date _____

Dental Work _____ Appointment Date _____

Routine Recall Exam at 6 months _____ at 1 year _____ Date _____

If examination was not completed, please indicate reason: _____

Dental health education provided: _____

_____ _____

Signature of Dentist Date

I hereby authorize all of my child's dental care providers and Drake University Head Start to release to each other and exchange between each other any and all information contained in the clinical records of my child listed above. Redisclosure to any 3rd parties is prohibited without my written consent.

_____/_____ _____/_____

Signature of Parent/Legal Guardian Date Signature of Witness Date

_____/_____

Signature of Parent/Legal Guardian Date

05/2024