OFFICE OF LAFAYETTE COUNTY PUBLIC HEALTH NURSE

DARLINGTON, WISCONSIN

To Parents / Guardians:

CHILD NAME: _____ SCHOOL: _____ AGE: ___

A regular periodic dental examination is an essential step in keeping your child's teeth healthy and is recommended by many schools. Please help your child maintain a strong healthy body by scheduling an appointment for him/her with your dentist.

Sign the release of information authorization statement below, take this form with you to the appointment and return this form to your child's teacher after the appointment. Thank you!

I authorize the below named dentist to release my child's dental records to my child's school.

_____ _____

Parent / Guardian Signature Date

TO BE COMPLETED BY DENTIST

Dentist Name: _____

Address: _____ City: _____ State: _____

Child's Name: _____ Date of Exam: _____

The following services were provided:

Oral Examination_____ Prophylaxis_____ Fluoride Treatment_____ X-Rays_____

The following observations were made:

_____ The patient needs no dental work and was scheduled for another exam in 6 months.

_____ The patient needs routine restorative treatment and is ____ is not ____scheduled.

_____ The patient needs extractions and is ____ is not ____scheduled.

_____ The patient would benefit by orthodontics and has ____ has not ____ been referred.

I certify that the services above have been performed.

Dentist Signature: _____ Date: _____