The completed dental exam can be faxed directly to Head Start at 801-781-3443. Thank you!

For HS Staff Use Only:

Date of parent permission form (HSAP1): ____________

Child's Name: ________________________________ **Date of Birth:** ____________________

Parent/Guardian's Name: ____________________ **Site/Class:** _____________________

Family Service Worker: ________________________________

Physician's/Clinic Name: __________________________________ **Physician's/Clinic Phone:** _______________

Insurance provider: _____________________________

Dental Exam Date: ______________________________

1. Services rendered: (please circle **all** that are applicable):

   Exam **X-rays** **Cleaning** **Fluoride** **Sealants** **Varnishes** **Education**

Please check appropriate box:

❒	❒	❒	❒	❒
Routine (No decay or problems)	**Low** (Few visible small, one surface lesions-no pulpal involvement, no pain, infection)	**Medium** (Several visible caries, no pulpal involvement, possible multiple surface involvement)	**High Need** (Many large caries, pulpal involvement likely, possible extraction, no infection)	**Emergency** (Active infection, possible abscess, pulpal involvement, pain, trauma)

2. Was child diagnosed as needing restorative treatment (NOT including sealants or varnishes)?
   ❒ Yes ❒ No—no treatment needed at this time

   If yes, has treatment begun? ❒ Yes ❒ No

   If yes, was treatment completed? ❒ Yes ❒ No If so, date completed:______________

3. If treatment needed, please indicate the number of treatment items needed as part of the treatment plan:

   Pulpotomies _____ **Restorations** ______ **Extractions** ______ **Crowns** ______

4. If more treatment is needed, next appointment date: ________________________________

5. The estimated amount of needed treatment not covered by insurance is: $_______________

____ ___________________________

Physician's Signature Date

Thank you!

NOTE to PARENT: to ensure coverage, please check your child's Medicaid or insurance policy before scheduling.