



Ohio School Health Record - Dentist's Report

Student's Name _____ Home Phone (____) _____

Street Address _____ City _____ Zip _____

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 _____ Dentist's Signature _____

Address _____ City/ State/ Zip _____

Telephone _____ Date Signed _____