Community Colleges of Spokane

Spokane County Head Start/ECEAP/EHS
DENTAL EXAMINATION RECORD

PARENTAL AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize: **Head Start/ECEAP/EHS AND Dental Provider:**

_____

To receive and disclose information regarding current dental exams, referral and/or treatment recommendations.

Child's name_____ Birth date_____

Site_____ Room no._____ ❒ A.M. ❒ P.M. ❒ Full day FSC_____

Parent/legal guardian (please print)_____

Parent's signature_____ Date_____

AUTHORIZATION IS VALID FOR PROGRAM YEAR, BEGINNING ____/____/____ and ending ____/____/____.
PARENT/GUARDIAN MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING.

DENTAL PROVIDER: PLEASE COMPLETE SECTIONS BELOW

Date of exam_____
- ❒ Pass
- ❒ Refer
- ❒ Fluoride varnish applied today.
- ❒ Dental treatment needed.
- ❒ Check if treatment has been completed.
- ❒ Check if further treatment is needed; EXPLAIN:

❒ Check if treatment has been discontinued. EXPLAIN:

Follow up treatment date_____

Next exam due_____

If this child is between one and two years of age do you recommend she/he brush with a small smear of fluoride toothpaste? ❒ Yes ❒ No

Name of dentist_____ Signature_____
(PLEASE PRINT)

Address_____ Phone_____

City_____ State_____ ZIP_____

PLEASE RETURN THIS FORM TO

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