The following form(s) can be filled in on-line, then printed for signatures and mailing or faxing.

To begin filling out the forms in Acrobat Reader, make sure the '**hand**' tool is selected then click on a line or in a box and begin typing. Check boxes can be clicked on or off.

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_____

VALID FOR ONE YEAR FROM DATE OF SIGNING. PARENT/GUARDIAN MAY REVOKE THIS AUTHORIZATION IN WRITING AT HIS/HER DISCRETION.

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:

Follow up treatment date_____

Next exam due_____

❒ Check if treatment has been discontinued. EXPLAIN:

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

Spokane County Head Start/ECEAP/EHS

Attention_____

Address_____

Phone_____