PRINCETON CITY SCHOOLS
EMPOWERING EACH STUDENT FOR COLLEGE, CAREER, AND LIFE SUCCESS

Student
Dental Assessment Form

Student's Full Name: _____ **Exam Date:**_____

Gender: **Male or Female** **DOB:** _____ **Age:** _____

Pre-school and Kindergarten students must have a current (within 1 year) physician's exam on file prior to admission & renewed every year during the named grades

The following services have been performed:

- ☐ Examination by Dentist
- ☐ Dental Sealants
- ☐ Oral Prophylaxis (cleaning)
- ☐ Orthodontic Assessment
- ☐ Radiographs
- ☐ Diagnosis
- ☐ Oral Screening
- ☐ Fluoride Application
- ☐ Rx for fluoride supplements

The following oral hygiene instruction was provided:

- ☐ Brushing teeth
- ☐ Flossing
- ☐ Diet counseling related to dental health
- ☐ Home/school use of fluoride mouth rinse

The following statements are applicable:

- ☐ No apparent care needed at this time.
- ☐ All necessary preventative services have been performed. (Fluoride treatment, prophylaxis)
- ☐ No restorative services are required at this time.
- ☐ Further treatment is indicated. (See comments)
- ☐ Further appointments have been arranged. (ex. Orthodontic, restorative)

Comments: _____

_____

_____

Examiner's Signature: _____

Examiner's Printed Name: _____

Dental Office Address: _____

_____

_____

Telephone: _____ **Fax:** _____

Please return this copy to your child's school or the Welcome Center