

BALTIMORE COUNTY DEPARTMENT OF HEALTH  
Division of School Health

School Dental Health Record

NAME OF STUDENT: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME OF SCHOOL: \_\_\_\_\_ AGE: \_\_\_\_\_

SCHOOL NURSE: \_\_\_\_\_ GRADE: \_\_\_\_\_

Please take this form to your family dentist when your child has his next dental appointment.  
Have your dentist complete the form and have your child return the form to the school nurse.

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REPORT OF DENTAL EXAMINATION:

- A.  No dental treatment is necessary
- B.  All necessary dental treatment has been completed
- C.  Treatment is in progress.

FURTHER RECOMMENDATIONS: \_\_\_\_\_

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\_\_\_\_\_

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\_\_\_\_\_  
Signature of Dentist

Date: \_\_\_\_\_

\_\_\_\_\_  
Please type or print Name of Dentist

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone: \_\_\_\_\_