Sacramento City Unified School District
EARLY LEARNING AND CARE DEPARTMENT

PRESCHOOL DENTAL HEALTH / EXAM RECORD

Child's Name: _____ Birthdate: _____ M___ F___

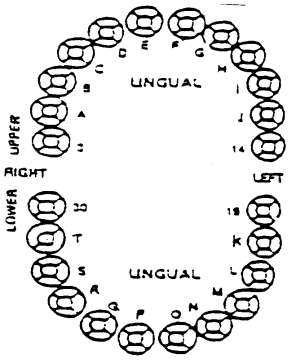
Parent/Guardian Name: _____ Phone: _____

Address: _____

I authorize professionally qualified people to exchange information about my child. I understand that all information will be kept in a confidential file.

Parent/Guardian Signature: _____ Date: _____

DENTAL PROVIDER:



PLEASE LIST ALL SERVICES PROVIDED BELOW AND COMPLETE SUMMARY:

Date of Service	Tooth # or Letter	Description of Services Provided

SUMMARY: ☐ No Treatment Needed ☐ Preventive Care Given ☐ Specialist Referral Given _____ ☐ Dental Treatment Received ☐ Approx. # of visits needed _____ Next Appointment Date _____

Dentist: _____ _____ _____
(Please print) (Signature) (Date)

Address: _____ Phone: (_____)_____

If treatment is not complete at this visit, please fill out a new form for each additional visit until treatment is completed. Please return completed forms to:

Early Learning and Care Department
Enrollment Center
5601 47th Avenue, Sacramento, CA 95824
(916) 395-5500 **Fax: (916) 428-4505**

For SCUSD Nurse Use Only:

☐ Dental Exam ☐ Pass/☐ Fail
☐ Preventive Dental Care Given
☐ Treatment given: _____
☐ Treatment In-Process
☐ Treatment Completed

☐ Approx. # of Visits Needed: _____
☐ Referred to Specialist: _____

Data Entry (initials/date): _____