Verification of Dental Examination / Treatment
Head Start

This is to certify that_____, was seen

for a dental exam on_____.

The child needs: (check what applies)

_____Received a Cleaning and Fluoride TX

_____No treatment needed
(Cleaning and Fluoride TX is not considered a treatment if received or needed)

_____Treatment needed:
(Includes fillings, extractions, crowns, and pulp)

_____Is receiving Treatment
(Has received a filling, extraction, crown or pulp TX)

_____Treatment complete (All prescribed treatment is Finished). Date: _____

Comments:
_____
_____
_____

Staff Initials: _____ Date: _____