TRENTON PUBLIC SCHOOLS
Trenton, New Jersey
Office of School Health Services

EC-5

DENTAL EXAMINATION/TREATMENT FORM

Section A: To be completed by parent/guardian

PUPIL'S NAME______________________________BIRTHDATE_________________

ADDRESS____

SCHOOL/GRADE____

Section B: To be completed by child's dentist

REPORT OF EXAMINATION

Please circle tooth (teeth) being treated

Tooth Chart																	
				RIGHT							LEFT						
UPPER	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	UPPER
				A	B	C	D	E	F	G	H	I	J				
LOWER	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	LOWER
				T	S	R	Q	P	O	N	M	L	K				

Comments: Please check all that apply

_____fluoride treatment

_____sealants

_____cleaning

_____x-rays

_____cavities treated

_____further treatment necessary

_____ treatment completed

_______________**date of next appointment**

____
Printed Name of Dental/Examiner

____
Signature of Dental/Examiner

____
Date

____
Phone Number

Please return this form to your child's school once it is completed by the dentist.

JD 2000, revised 5/2008