SYCAMORE COMMUNITY SCHOOLS
*Our students. Our future.*

# DENTAL REPORT

*To be completed by student's dentist.*

**Today's Date _____**

**Name of Child _____**

**Date of Birth _____ School _____ Grade _____**

**The following services have been performed (please check all that apply):**

_____ X-rays

_____ Oral prophylaxis

_____ Fluoride treatment

_____ Restorations

**The following statements are applicable:**

_____ All necessary services have been performed.

_____ No restorative services are required at this time.

_____ Further treatment is indicated.

_____ Future appointments have been arranged.

**Additional Comments:**

_____

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**Signature of Dentist** **Date**

_____

**Printed Name of Dentist** **Date**

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