Ohio School Health Record
Dentist's Report

Student Name: _____ Grade: _____

The following services have been performed:

☐ Examination ☐ Radiographs ☐ Prescription for fluoride supplements
☐ Diagnosis ☐ Oral Prophylaxis ☐ Topical application of fluoride

The following oral hygiene instruction was provided:

☐ Tooth-brushing ☐ Diet counseling reflecting relation of diet to dental health
☐ Flossing ☐ Home / School use of fluoride mouth rinse

The following statements are applicable:

☐ All necessary services have been performed ☐ Further treatment is indicated
☐ No restorative services are required at this time ☐ Further appts. have been arranged

Comments: _____

_____

_____

PLEASE PRINT OR STAMP

Dentist's Name: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

Dentist's Signature: _____ Date: _____