Berkeley County Schools Pre-K/Head Start
Dental Exam

Child’s Name ___________________________ Date Exam Completed __________
Birthdate ____________________________

ORAL CONDITION

UPPER

Number of times per day child brushed teeth ________

Gum Condition:
____ Normal    ____ Swollen    ____ Bleeds Easily    ____ Infected

Dental Needs:
____ None    ____ Treatment    ____ Cleaning    ____ Fluoride Supplement    ____ Oral Hygiene Instruction
____ Other: __________________________________________________________________________

Follow-up Needed:   No   Yes   Reason __________________________________________________________________________________

Signature: ___________________________ Stamp: ___________________________
Printed __________________________________________________________________________
Address: __________________________________________________________________________
Phone ____________________________________________________________________________

Return to:  Berkeley County Schools Pre-K / Head Start    (Fax) 304-267-3557    (Phone) 304-267-3555