Berkeley County Schools Pre-K/Head Start
Dental Exam

Child's Name_____ Date Exam Completed _____

Birthdate _____

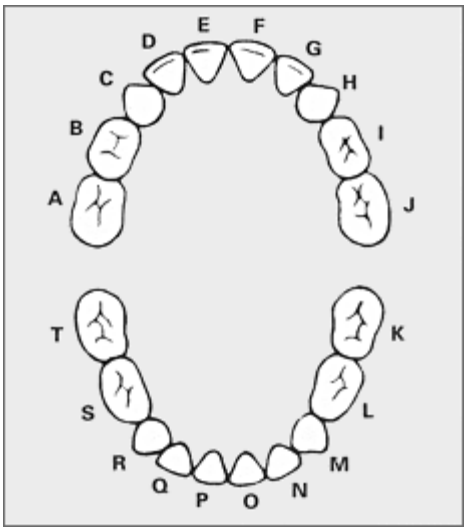
ORAL CONDITION

UPPER

Key

X Missing
Decayed
Filled

LEFT



RIGHT

LOWER

****

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