

Lafayette County Health Department
729 Clay Street - Darlington, Wisconsin 53530
(608) 776-4895 - Fax (608)776-4885

To Parents / Guardians:

CHILD NAME: _____ SCHOOL: _____ AGE: _____

A regular periodic dental examination is an essential step in keeping your child's teeth healthy and is required by many schools. Please help your child maintain a strong healthy body by scheduling an appointment for him/her with your dentist.

Sign the release of information authorization statement below, take this form with you to the appointment and return this form to your child's teacher after the appointment. Thank you!

I authorize the below named dentist to release my child's dental records to my child's school.

Parent / Guardian Signature

Date

TO BE COMPLETED BY DENTIST

Dentist Name: _____

Address: _____ City: _____ State: _____

Child's Name: _____ Date of Exam: _____

The following services were provided:

Oral Examination _____ Prophylaxis _____ Fluoride Treatment _____ X-Rays _____

The following observations were made:

_____ The patient needs no dental work and was scheduled for another exam in 6 months.

_____ The patient needs routine restorative treatment and is _____ is not _____ scheduled.

_____ The patient needs extractions and is _____ is not _____ scheduled.

_____ The patient would benefit by orthodontics and has _____ has not _____ been referred.

I certify that the services above have been preformed.

Dentist Signature: _____ Date: _____