SUU SOUTHERN UTAH UNIVERSITY
STARTING LIVES FOREVER

Head Start Dental Screening

Child's Name:	Center/Class:
Parent's Name:	Child's Birthdate:

DENTIST INFORMATION

Dentist Name: Phone Number: ( ) -

Clinic Name (if different): Fax Number: ( ) -

Clinic Address:

City/State/Zip code:

SCREENING AND TREATMENT RECORD

(List recommended services in order)

Tooth # or Letter	Surfaces	Description of work	Treatment Approved	Date Service Performed MO	DAY	YR	Actual Charges (fee)	

CHILD SCREENING RESULTS

- ❑ NEED TREATMENT (restoration, pulp therapy, extraction)
- ❑ OTHER_____
- ❑ NO PROBLEMS

Approximate number of visits needed: _____

Approximate cost: _____

Dentist Signature: Date:

CHILD DENTAL WORK COMPLETION

Only complete this section if all dental work is accomplished and the child has no more immediate

I certify that I have completed the service(s) listed in "SCREENING AND TREATMENT RECORD", and that the charges do not

Dentist Signature: Date:

I hereby authorize the release of any information from a Head Start related exam or followup be released to SUU Head Start for

Parent/Guardian Signature: Date:

1st Copy-- Head Star 2nd Copy-- Provider