ORAL HEALTH ASSESSMENT FORM

SECTION 1

To be completed by the parent or the gaurdian

Child's Last Name:	Given Name:	Birth Date:
School Name:	Grade:	Gender ☐ Male ☐ Female
Address:		
Parent / Gaurdian Name:		

SECTION 2

To be completed by the dental professional conducting the assessment

Assessment Date:	Visible caries present: ☐ Yes ☐ No	Fillings present: ☐ Yes ☐ No	Treatment Urgency ☐ No bvious problem found ☐ Early Dental care recomended ☐ Urgent care needed

Stamp or print examiner's name, address & phone number.

Dental professional's Signature: _____

Date: __/__/____