UMFS

Treatment Foster Care Services

Report of Dental Examination

Name of Child: _____ Date of Exam: _____

DOB: _____

This is to certify that _____ had a dental examination on the above date.

Dental cleaning was performed ☐ Yes ☐ No

Additional dental work performed:

_____

_____

_____

Recommendation include:

_____

_____

_____

Signature of dentist or designee _____Date_____

Address: _____

_____

_____