# 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: _____