## Ohio Department of Health • School and Adolescent Health Oral Assessment

Student's name				Date of birth		
					/	
The following services have been	en performed (please check a	ll that apply)				
Examination	Fluoride application			Prescription for fluoride supplement		
☐ Orthodontic assessment	Radiographs	Dental sealant	∐ Tr	☐ Treatment (restoration, pulp therapy)		
Other						
The following oral hygiene inst	ruction was provided (pleas	e check all that apply)				
☐ Toothbrushing	☐ Flossing	Dietary counseling	Пи	Use of fluoride mouthrinse		
Other	•			a ose of hadride modalinise		
The following statements are a	oplicable (please check all that	apply)				
☐ All necessary preventive services						
No restorative services are requi		accument, propriguality				
Further treatment is indicated.(S						
Further appointments have beer		ative)				
Routine recall visits recommende	ed.					
Comments						
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Dentist's signature Print name				Phone		
				( )		
Address				Date /	,	
City			State	ZIP		