

**DRAKE UNIVERSITY HEAD START/EARLY HEAD START/EHS-CCP**  
**DENTAL EXAM – Birth to 5 years**  
**3800 Merle Hay Rd., Suite 323, Des Moines, IA 50310, Fax: 515-635-0716**

Child's Name: \_\_\_\_\_ Program: \_\_\_\_\_

Dental Office Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Has this child had previous dental care?    Yes    No

**SERVICES PROVIDED:**

Month	Day	Year	Description of Work

**DRAKE UNIVERSITY HEAD START REQUIRES THE CHILD BE SEEN BY A DENTIST!**

Needs to return for:    Urgent Care \_\_\_\_\_                      Appointment Date \_\_\_\_\_

  Dental Work \_\_\_\_\_                      Appointment Date \_\_\_\_\_

  Routine Recall Exam at 6 months \_\_\_\_\_ at 1 year \_\_\_\_\_ Date \_\_\_\_\_

If examination was not completed, please indicate reason: \_\_\_\_\_

Dental health education provided: \_\_\_\_\_

\_\_\_\_\_  
Signature of Dentist

\_\_\_\_\_  
Date

I hereby authorize all of my child's dental care providers and Drake University Head Start to release to each other and exchange between each other any and all information contained in the clinical records of my child listed above. Redislosure to any 3<sup>rd</sup> parties is prohibited without my written consent.

\_\_\_\_\_/\_\_\_\_\_  
Signature of Parent/Legal Guardian    Date                      Signature of Witness                      Date

\_\_\_\_\_/\_\_\_\_\_  
Signature of Parent/Legal Guardian    Date