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

Student's name			Date of birth		
				/	/
The following services have bee	en nerformed (please check all t	hat anniv)			
☐ Examination					I1
Orthodontic assessment	☐ Fluoride application ☐ Radiographs	☐ Oral prophylaxis (cleaning)☐ Dental sealant	☐ Prescription for fluoride supplement☐ Treatment (restoration, pulp therapy)		
	□ Radiographs	Dental sealant			
Other	·				<del></del>
The following oral hygiene inst	ruction was provided (please of	theck all that apply)		***	·
☐ Toothbrushing	☐ Flossing	☐ Dietary counseling	Use of fluoride mouthrinse		
Other					
		·-·			
The following statements are a	DD <b>licable</b> (please check all that a	nolv)			
All necessary preventive services  No restorative services are requi		reatment, prophylaxis)			
Further treatment is indicated.(					
Further appointments have been		ve)			
Routine recall visits recommend		•			
Comments					
-					
Dentist's signature	Prin	nt name		Phone	
Address				Date	
Addiess				/	/
City			State	ZIP	,