

**LOUISIANA DENTAL ASSOCIATION
SCHOOL DENTAL HEALTH RECORD**

Parent instructions:

1. Fill out the top portion of this form.
2. Select a dentist from the attached list.
3. Call to schedule an appointment with the dentist you selected; bring completed form to dentist's office.
4. In an effort to service as many students as possible, the dentist will fax the completed form to your child's school after you have attended the scheduled appointment. An additional letter will be sent to parents who have not submitted this form to the dentist or returned this form to the school.

To be filled out by parents

Student: _____ **School:** _____

Parent/Guardian: _____

Phone: Home: _____ **Cell:** _____

_____ **I am interested in pursuing dental care for my child at this time.**

_____ **I already have a dentist who treats my child.**

To be filled out by Dentist

Date of Dental Exam: _____

Name of Dentist: _____

Office Address: _____

Telephone Number: _____

_____ All treatment complete
Next follow-up due: _____

_____ Additional treatment needed
Appointment scheduled: _____

Signature of Dentist

Date