Dentist:_____ _____ _____
(Please print) (Signature) (Date)

Address:_____ Phone: (____)_____

If treatment is not complete at this visit, please fill out a new form for each additional visit until treatment is completed
Please return completed forms to:

Child Development Department
Hiram Johnson Family Education Center
3535 65TH Street, Sacramento, CA 95820
(916) 395-5500 Fax: (916) 277-6698

For SCUSD Nurse Use Only: ☐ Dental Exam ☐ Pass ☐ Fail ☐ Approx. # of Visits Needed: _____
☐ Preventive Prophy/Fluoride Varnish ☐ Referred to Specialist: _____