Los Alamos Public Schools	**Pre-School and Kindergarten Dental Health Appraisal**

School child will attend: ☐ Pre-School ☐ Kindergarten

Student: _____
Last First MI

Birth Date ____/____/_____ Gender ☐ Male ☐ Female School Year _____

Parent/Guardian: _____
Last First Relationship

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Dentist: _____

Phone # _____ Fax #_____

Date of Examination: _____

Date child should return for next examination: _____

Doctor: Please check the appropriate boxes.

☐ Yes ☐ No	2. This child is still under treatment.
☐ Yes ☐ No	3. I have completed the necessary dental treatment.

Dentist's recommendation to the school: _____

_____

_____

_____

_____ _____
Signature of Dentist Date

Parent: Please return this form to the school nurse's office.

LAPS Date Received: _____

5142R Health Examinations and Immunizations
Addendum 3 Pre-School and Kindergarten Dental Health Appraisal
(Revised 03/2017)