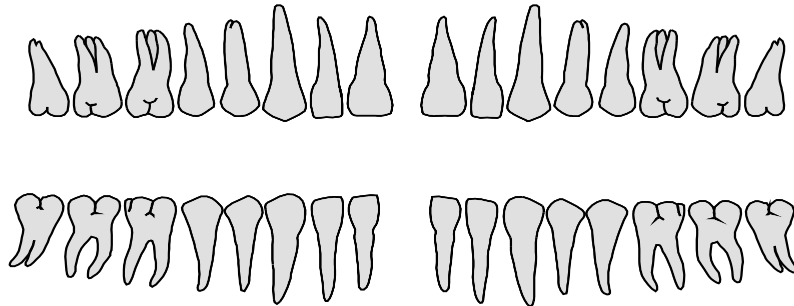
KIDS COUNT TOO, INC.
Foster Care Agency

Dental Examination

Child's Name: ________________________________ Today's Date: ____________________



Carious – mark ✓ Filled – mark **X** Absent – **0** Dirty – line across

Treatment Needed: ____

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Treatment Provided: ____

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Diagnosis / Remarks: ____

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Doctors Name: _______________________________________

Address: ____

____

Phone Number: _______________________________________

____ ____________________

Signature of Dentist Date

Approved (4 / 02)