iAngel Learning Center

5513 D.M. rivera St. Poblacion Makati City

DENTAL EXAMINATION

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
Last First Middle		☐ M ☐ F		

ADDRESS

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Remarks:

55	54	53	52	51	61	62	63	64	65
85	84	83	82	81	71	72	73	74	75

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis ☐

☐ **Other** — periodontal, orthodontic

Date of Dental Examination

Signature of Dental Examiner

Print Name of Dental Examiner

Return Slip

To be filled up by Private Dentist and returned to School after Dental Defects have been corrected.

Name of Student

Is the Child under treatment ☐ Yes ☐ No

Treatment completed ☐ Yes ☐ No

Remarks

Name of Dentist

Date