

# Child Dental Statement

Fort Recovery Public Preschool 419-375-4131

**Child's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

This child has been examined by a licensed dentist and needs the following treatment:


Dentist Signature: \_\_\_\_\_

License Number: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

**State reason not completed**

Health Professional Decision, Religious Conviction, Insurance Coverage or other