School: _____

Alachua County Public Schools
Early Intervention Services
Head Start Program

Verification of Dental Treatment

This is to certify that _____ is one of my regular patients and was last seen in my office on _____.

The following applies to this patient:

- ☐ Needs no treatment at this time
- ☐ Needs a routine examination in the month of _____
- ☐ Needs the following services:

  _____

  _____

  _____
- ☐ Appointment scheduled for _____

Comments:

Provider Stamp

_____
Signature of Dentist

_____
Print Name

_____
Date

As Parent or Legal Guardian of _____, I hereby give my permission for the above information to be released to the Head Start Program.

Parent or Legal Guardian _____ Date _____

Dental Provider: _____

Return to: **Fearnside Family Services Center**
3600 N. E. 15th Street
Gainesville, FL 32609-2484

or Fax to: **352-955-7223**

Distribution
___ Central File
___ Health Coordinator
___ Dentist
___ Health Team