David & Margaret Foster Family Agency
Dental Examination Form

Name of Child: _____

Date of Birth: _____ Date of Exam: _____

Results of Examination: _____

_____

_____

Any Complications: _____

_____

_____

Next Check-Up Date: _____

Recommendations: _____

_____

_____

PLEASE PLACE STAMP AND SIGNATURE HERE
(Please include doctor's name, address and phone number)

*****NOTE*****

THIS FORM IS TO BE USED FOR ALL DENTAL EXAMINATIONS AND CARE.

_____
COUNTY SOCIAL WORKER PHONE NUMBER

_____
D&M SOCIAL WORKER PHONE NUMBER

_____
EXTENSION

WebSite 2-22-16

David & Margaret
Youth and Family Services
Foster Care and Adoption Services
1350 Third Street, La Verne, CA 91750
(909) 593-0089, **fax (909) 596-7583**

REPORT OF PHYSICAL EXAMINATION FOR CHILD IN FOSTER CARE

Signature of Staff Social Worker _____

Print Name	*Date and Time*

* * * * *

Supervisor's Remarks (including administrative follow-up):

Supervisor's Signature _____

Print Name	*Date and Time*

* * * * *

Distribution:

	Name of Person Contacted	*Telephoned (Date)*	*Written/Fax (Date)*
Parent(s)/Guardian			
County Worker			
Licensing			
Monitor			
Child Abuse Report			
Police Report No.			
Other:			