MANITOWOC COUNTY FOSTER CARE PROGRAM

Strengthening Families Through Foster Care

DENTAL EXAMINATION

Child's Name: _____

Foster Parent's Name: _____

Date of dental exam: _____

Summary of exam/recommendations: _____

_____

Dentist signature

_____

Dentist Name (print please)

_____

Return to: Foster Parent or

Manitowoc County
Human Services Department
P.O. Box 1177
Manitowoc WI 54221-1177