ECAP Project V.I.L.L.A.G.E.
Indian River School District
30207 Frankford School Rd
Frankford, DE 19945
302-732-1346
Fax: 302-732-1344

Dear Dental Provider:

As part of the Early Childhood Assistance Program (ECAP) children are to receive an annual dental exam. Please complete the following information. Thank you for your support in providing high quality services to our families.

_____ was seen in my office on _____
(Child Name) (Date)

1. **The following services were provided:**

   - ☐ Oral Examination
   - ☐ Cleaning
   - ☐ Fluoride Treatment
   - ☐ X-Rays

2. **Additional treatment needed** (check one):

   ☐ Yes, this child will have ____ additional appointment(s**)** ☐ No

3. **What treatment is/was needed?** (If applicable):

   - ☐ Fillings
   - ☐ Extractions
   - ☐ Primary
   - ☐ Sealants
   - ☐ Root Canals
   - ☐ Other _____

4. **Follow-up/treatment completed on**: _____
   (Date)

5. **Additional Comments: _____**

_____ _____
(Dental Provider Signature) (Date) (Dental Provider Printed Name)

_____ _____
Street Address City, State, Zip (Phone Number)

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