Dear Parents

We strongly urge you to make an appointment with your dentist. If your child has received treatment, please have this form completed by the dentist and return it to your child’s school nurse.

Levittown Public Schools-Division of Health Service
Student Annual Dental Examination Report
(to be completed by Dentist)

Student Name:__________________________ Grade:_______ School:____________________

The above child has had his/her teeth examined and the necessary work is:

Completed:__________ Under treatment:____________ Does not need Treatment:_______

1. The occlusion was found to be: Faulty__________ Good_________

2. Is child receiving orthodontia: Yes_________ No____________

3. Is orthodontia recommended: Yes___________ No____________

4. Remarks:__________________________________________________________

__________________________________________________________

_________________________          ___________         ______
Dentist Signature          Dentist Stamp         Date