DENTAL

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 SERVICES
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: ____________________________________________

___________________________________________________________________________

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Dentist’s Signature  _______________  Dentist’s Stamp  _______________  Date  _______________