SOUTHEAST DELCO SCHOOL DISTRICT

DEAR PARENT/GUARDIAN OF ______________________,
THE SCHOOL HAS NOT RECEIVED A DENTAL EXAM FOR YOUR CHILD. PLEASE HAVE YOUR FAMILY DENTIST COMPLETE THIS FORM AND RETURN IT TO THE SCHOOL NURSE. IT IS A STATE MANDATED REQUIREMENT.

Family Dentist Report

*Name of Child*______________________ *School*______________________

*Grade*__________ *Room*___________ *Teacher*____________________

*The above named child last visited my office on*____________________

All necessary dental corrections have been made: yes____ no____

If the answer is NO, please complete the following:

Primary teeth___ Fillings___ Extractions____
Permanent teeth___ Fillings____ Extractions____
Diseases of the supporting tissues____
Gross malocclusion___Congenital malformations____
Prosthetic replacements for lost or missing teeth____

This child is currently under treatment: yes___ no___

*Name:*____*D.D.S./D.M.D.*

Please Print

*Address:*____

*Signature:*____