

STEEL VALLEY SCHOOL DISTRICT DENTAL HEALTH SERVICE

DEAR PARENT /GUARDIAN:

All Students in Grades 1, 3, and 7 are **required** by the Commonwealth of Pennsylvania to have a dental examination. Your family dentist may do this examination during the summer months. Please consult your dentist for a routine checkup or examination.

Please have your dentist complete the bottom of this form and return to the school by September 10th. If this is completed during the summer months, your child need not be scheduled for a dental examination during the school term.

School Nurse

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH
DENTAL HEALTH

FAMILY DENTIST REPORT

SCHOOL DISTRICT	COUNTY	POST OFFICE
NAME OF CHILD (LAST) (FIRST) (MIDDLE)	BIRTHDATE	SEX
HOME ADDRESS	POST OFFICE	

THE ABOVE NAMED CHILD LAST VISITED MY OFFICE _____(DATE) AT THAT TIME ALL NECESSARY DENTAL CORRECTION HAVE BEEN MADE YES _____ NO _____

IF THE ANSWER IS NO FILL IN THE FOLLOWING:

PRIMARY TEETH _____ FILLING _____ EXTRACTIONS _____

PERMANENT TEETH _____ FILLING _____ EXTRACTIONS _____

DISEASE OF THE SUPPORTING TISSUES _____

GROSS MALOCCLUSION THAT IS PRODUCING A FACIAL DEFORMITY OR IS INTERFERING WITH FUNCTION _____

CLEFT PALATE AND/OR CLEFT LIP _____ OTHER MALFORMATIONS _____

PROSTHETIC REPLACEMENTS FOR LOST OR MISSING TEETH _____

THIS CHILD IS CURRENTLY UNDER TREATMENT YES _____ NO _____

SIGNATURE _____ D.D.S.

DATE SUBMITTED _____ ADDRESS _____