

Dear Parent/Guardian of _____:

You have opted to have the required 7th grade dental exam completed by your family dentist. This exam may have been done within the past year. Your dentist will complete this form for you. The form needs to be returned to your school nurse by December.

If you have any questions, please phone your school and ask to speak with the school nurse.

Sincerely:

Cathy Smith R.N., C.S.N.
Union City District Nurse

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

**PRIVATE DENTIST REPORT OF
DENTAL EXAMINATION OF A PUPIL OF
SCHOOL AGE**

NAME OF SCHOOL _____ DATE _____ 19__

NAME OF CHILD			AGE	SEX	GRADE	SECTION/ROOM
Last	First	Middle		<input type="checkbox"/> M <input type="checkbox"/> F		

ADDRESS _____

No. and Street	City or Post Office	Borough or Township	County	State	Zip
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REPORT OF EXAMINATION

	TOOTH CHART																
	RIGHT								LEFT								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
UPPER				A	B	C	D	E	F	G	H	I	J				Upper
LOWER	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	Lower
																	Upper
																	Lower

Is The Child Under Treatment Yes No

Treatment Completed Yes No

Date of Dental Examination

Signature of Dental/Examiner

Print Name of Dental Examiner

Address