**DENTAL EXAMINATION FORM**

**This form must be returned to your child’s school nurse no later than 30 days after the student’s start of school date.**

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| **Child First and Last Name** |
| **Child Street Address and Phone Number** |
| **I have completed a dental examination on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **date** |
| **Examination Findings: Please Check one:**  \_\_\_\_\_\_\_\_\_\_This child has normal dental screening and does not require dental treatment at this time  \_\_\_\_\_\_\_\_\_\_ This child is receiving dental treatment  \_\_\_\_\_\_\_\_\_\_This child is in need of dental treatment |
| Dentist Signature and office stamp and Date  Office Stamp  Dentist Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |