

MIDDLESEX COUNTY EDUCATIONAL SERVICES COMMISSION

DENTAL FORM

Date: _____ Student Name: _____ Grade: _____

Dear Parent Guardian:

The school health policy recommends an annual dental examination by your family dentist for each child.

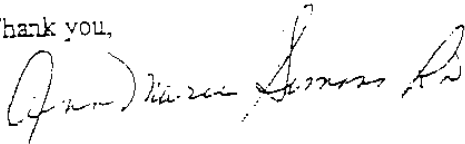
The form below is to be completed. If your child has had an examination in the last six (6) months, please have the dentist complete this form.

Please return this form to the school nurse as soon as possible following your child's dental examination.

If there is any reason why you cannot have a dental examination done, please call me at

838 1657

Thank you,



School Nurse

I have examined _____ on _____
Student Name *Date*

- 1. There is no need for corrective work at this time.
- 2. Treatment has been completed
- 3. There is need for dental care at this time
Has an appointment been scheduled? YES NO

Dentist's Signature *Date*

Printed Name and Address of Dentist:

