STEEL VALLEY SCHOOL DISTRICT
HEALTH SERVICES

TO PARENT AND/OR 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. If this is completed during the summer months, your child need not be scheduled for a dental examination during the school term and can turn this form in at the beginning of the school year.

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 __________________________________