

REPORT OF SCHOOL DENTAL EXAMINATION

This is to certify that I have examined the teeth of

Name

Grade

- No dental treatment is necessary.
- Treatment has been recommended.
- Treatment is in progress.
- Treatment completed.

Further recommendations or comments: _____

Date

Signature of Family Dentist

PLEASE RETURN THIS CARD TO THE TEACHER WITHIN 60 DAYS OR

BEFORE _____
Date

S. H. 21 '71
(over)

