WILLIAMSBURG COMMUNITY SCHOOL DISTRICT
Student Health Services
DENTAL EXAMINATION

Dear Parent or Guardian:

Pennsylvania School Law requires a dental examination on all children entering school (kindergarten or 1st grade), 3rd and 7th grade. The examination may be done in school or by your family dentist.

WE RECOMMEND YOUR FAMILY DENTIST DO THIS EXAMINATION SINCE THEY CAN BEST EVALUATE YOUR CHILD'S DENTAL HEALTH AND ASSIST YOU IN OBTAINING THE NECESSARY TREATMENTS AND CORRECTIONS.

We are providing the necessary forms to you early so that you may have an opportunity to have the examination completed by the time your child enters the designated grade.

According to STATE LAW, if a private dentist's form is not returned, the examination will be scheduled and done by the school dentist. You would be notified when the school examinations are to be done.

Please return the completed family dentist report to the school nurse at the beginning of the school year. If it has not been completed at that time, please indicate the date or your child's appointment, **and return the completed report form after the examination**, or indicate that you wish to have your child examined by the school dentist. If you have questions regarding this program, please contact the school nurse.

Respectfully,

Christine Ebersole, RN, BSN, CSN

PLEASE FILL OUT THIS PORTION IF THE DENTAL EXAM AND FORM ARE NOT COMPLETED WHEN STARTING SCHOOL

To the School Nurse:

Child's Name _____ Grade _____

_____ I wish to have my family dentist examine my child. Provide the date of appointment and name of the dentist if this has not been completed. Please provide a copy of the Dental Exam.

Date of Appointment: _____

Name of dentist: _____

_____ I wish to have the examination done in school by the school dentist.

_____ I wish to have the examination/cleaning done in school by the mobile dentist

Parent/Guardian Signature: _____ Date: _____

H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____ 20 ___

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
Last First Middle		☐ M ☐ F		

ADDRESS

No. and Street | City or Post Office | Borough or Township | County | State | Zip

REPORT OF EXAMINATION

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