



DENTAL EXAMINATION FORM



Name of Student: _____ **Date of Birth:** _____

I have examined this child and found:

- | | | |
|--|-----|----|
| 1. The child is in need of dental treatment: | Yes | No |
| 2. The child is receiving dental treatment: | Yes | No |
| 3. The child has completed dental treatment: | Yes | No |

Does the child have any oral/dental conditions the school should be aware of?

Dentist Signature _____ Date _____

Dentist Stamp

