PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT
OFFICE OF THE SCHOOL NURSE

DENTAL HEALTH CERTIFICATE

STUDENT'S NAME____

SCHOOL__________________________ TEACHER____________________

Dear Parent or Guardian:

New York State law (Chap. 281) instructs schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. We recommend that each student visit the dentist every six (6) months in order to maintain good dental health, however, we request only one dental form during the above school years. Please ask your dentist to complete this form and return it to your school nurse.

TO BE COMPLETED BY THE DENTIST

THIS IS TO CERTIFY THAT A DENTAL EXAMINATION IS COMPLETE AND TO INFORM YOU THAT:

(PLEASE CHECK ANY THAT APPLY)

NO TREATMENT IS NECESSARY AT THIS TIME ____________
TREATMENT IS ADVISED AND IN PROCESS ____________
TREATMENT IS COMPLETED ____________

MALOCCLUSION IS PRESENT ____________
MALOCCLUSION IS NOT PRESENT ____________

ORTHODONTIA IS IN PROGRESS ____________

OTHER COMMENTS

____

____

____

DATE:________________

____
(DENTIST'S SIGNATURE)

____
(DENTIST'S NAME PRINTED)

____
(DENTIST'S ADDRESS)

____
(DENTIST'S PHONE #)