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 #)