

PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT

106 Washington Avenue, Plainview, New York 11803

www.pobschools.org



Dental Health Certificate

Student's Name: _____

School: _____

Teacher: _____

Dear Parent or Guardian:

New York State law (Chapter 281) permits schools to request a dental examination in the following grades: All New Students, Pre-K or K, 1, 3, 5, 7, 9 & 11. We recommend that each student visit the dentist every six (6) months in order to main 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 IN 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 Printed Name: _____

Dentist's Address: _____

Dentist's Phone Number: _____