

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, 1, 3, 5, 7, 9, 11. 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 #)