

Dental Examination Record
Oregon-Davis Elementary School

Child Name _____ DOB: _____
Grade: _____

Parent/Guardian: _____ Phone: _____

Address: _____

Report of Dental Examination

This is to certify that I have examined the teeth of _____,
and wish to report the following to the school.

_____ 1. All necessary work has been completed.

_____ 2. Treatment is in progress.

_____ 3. No dental work is necessary at this time.

_____ 4. Other:

Signature of Dentist: _____

Address: _____

Phone: _____

This form is to be completed by your family dentist and returned to school at fall registration.