The School District of Philadelphia

**REPORT OF PRIVATE DENTAL EXAMINATION**

|  |  |  |
| --- | --- | --- |
| Name of School | Student ID | Date Issued |
| Name of Student | Date of Birth |  |

**TO THE DENTIST**

PENNSYLVANIA LAW REQUIRES THAT STUDENTS ATTENDIN SCHOOL IN THE Commonwealth receive periodic dental examinations a stated intervals (upon original entry, while in third grade and while in seventh grade.)

These examinations are required for school attendance. Payment for these exqmi8nati8ons is the responsibility of the parent/guardian. If the student/family does not have health insurance, the school nurse will help the family apply for health insurance. Please attach a copy of the student’s dental examination or record the data below.

Thank you for your cooperation.

|  |  |
| --- | --- |
| **UNDER TREATMENT/WORK BEGUN** | **COMPLETION OF WORK/NO TREATMENT NECESSARY** |
| Date Work Begun |  \_\_\_\_\_ No Treatment Required Now |
| Scheduled Follow-up Appointments |   \_\_\_\_\_ All Necessary Dental Work Completed |
| Date of Dental Examination | Expected Completion Date |
| Comments/Follow-up Treatment/Special Instructions to School |  |
| Name of Dentist | Telephone |
| Signature of Dentist | Date Signed |
| Address | Fax Number |

**Important:**

 **Return this form to**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Certified School Nurse/Practitioner

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 School

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 School Address

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone Number