Plum Borough School District

Nursing Services Department

Dental Exam Needed for Grades K, 3, and 7

Dear Parent or Guardian:

Pennsylvania School Health Law requires that students entering Kindergarten (or 1st grade if student skipped grade K), and students in 3rd and 7th grade, receive a dental examination. These examinations may be done by your family dentist or by the school dentist.

Families are encouraged to establish a relationship with a family dentist, to assure continuity of treatment that is not possible in school exams. This is a lesson, which if learned, will pay dividends in adult life.

If you desire your family dentist to perform the exam, please have the form below completed by the dentist, and return it to the nurse's office on the first day of school or as soon as possible thereafter. If your child had an exam within 1 year of the beginning of the grade in which the exam is due, you do not need to repeat the exam, just have your dentist complete the form based upon the last exam. **As detailed in the parent handbook, failure to submit a completed form by January 15th indicates implied consent for a school dental screening to be completed.**

Thank You for Your Cooperation,

Your School Nurse

Plum Borough School District

Nursing Services Department

Private Dentist Report

Student's Name ________________________________ Grade _____ Date of Birth ________

Last First

Dental Examinations are mandatory for students entering Kindergarten (or 1st grade if student skipped grade K), and for students in grades 3 and 7. You may have your dentist complete this form based on an exam during this year, or an exam done within a year of entering the grade in which the examination is required.

The above named child last received a dental exam on (give date): ________________________

At that time all necessary corrections were made: Yes _____ (If Yes, place signature below.)

No*_____ (If No, please complete the following section, then sign below.)

***The child is in need of treatment for one or more of the following:**

_____ Filling(s) of Primary Teeth _____ Extraction(s) of Primary Teeth

_____ Filling(s) of Permanent Teeth _____ Extraction(s) of Permanent Teeth

Does the child have any gross malocclusion producing a facial deformity or interfering with function or Any Prosthetic replacements for lost or missing teeth? (specify):_________________________________

Child is currently under treatment: Yes _____ No _____ (If Yes, specify):_______________________

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Dentist's Signature _______________________________________ Date ___________ Phone _______________