

**MT. LEBANON SCHOOL DISTRICT
HEALTH SERVICES**

#412 (3-04)

FAMILY DENTAL REPORT

DUE on or before October 1

| | | |
|---------------|----------|----------------|
| NAME OF CHILD | SCHOOL | GRADE/ ROOM |
| HOME ADDRESS | ZIP CODE | PHONE # |

DENTIST PLEASE COMPLETE THIS SECTION

The above named child last visited my office on _____.
At that time all necessary dental corrections had been made.

Dentist's signature _____

Dentist's address _____

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