



Dental Examination Report

This card should be completed by your dentist and returned to the appropriate campus.

Student's Name: _____ **Grade:** _____

Date of Exam: _____

Dentist's remarks on dental condition: _____

Dentist's Signature

Elementary Campus
905 South Waterloo Road
Devon, PA 19333
484-654-2400

Upper Campus
462 Malin Road
Newtown Square, PA 19073
610-353-6522