

**MAMARONECK UNION FREE SCHOOL DISTRICT**

**Mamaroneck, NY 10543**

**DENTIST CERTIFICATE**

**TO BE COMPLETED BY PARENT/GUARDIAN:**

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**School:** \_\_\_\_\_ **Grade Level:** \_\_\_\_\_ **Teacher:** \_\_\_\_\_

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**TO BE COMPLETED BY DENTIST:**

**Date of Last Examination:** \_\_\_\_\_

**Check work that was completed at the last examination:**

**Inspection**       **Cleaning**       **Repair**       **No Treatment**

**Please provide any information about the child's dental health that the school nurse should be aware of:**

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

**Name of Dentist (please print):** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Dentist Office Stamp (required):**