CLARKSTOWN CENTRAL SCHOOL DISTRICT
HEALTH SERVICES

Name of Pupil:_____**D.O.B.**_____

School:_____**Grade:**_____

Dear Parent or Guardian:

As required by law, please have this form filled out by your family dentist at the time of your child's dental examination. Treatment and correction of any defects found by the dentist, as soon as possible, is most desirable for your child's dental health.

- ( ) **This patient has had a dental examination.**
- ( ) **Requires no dental treatment at this time.**
- ( ) **Is under dental treatment at this time.**
- ( ) **Has completed all dental treatment.**

Remarks:_____

Date:_____ _____

Signature of Dentist

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE.

Form #6