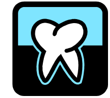

Dental Examination Record
Examen Dental

Verona Area School District
Verona, WI 53593

PLEASE TAKE THIS FORM TO YOUR FAMILY DENTIST
POR FAVOR, ENTRÉGUELE ESTE FORMULARIO A SU DENTISTA

Child's Name: ____

Address: ____

School: ________________________________ Grade: ______________

This child has been seen for examination. Any dental problems have been discussed with the parents.

Signature of Dentist: ___________________________ Date: __________

Please print or stamp:

Dentist Name:

Address:

City, State Zip:

Phone:

PLEASE RETURN THIS FORM TO THE SCHOOL OFFICE

POR FAVOR, DEVUELVA ESTE FORMULARIO A LA OFICINA DE LA ESCUELA