Dental Form

Somers Middle School
250 Rt 202
Somers, NY 10540
Health Office
(914)277-4099
Fax (845)276-7636

Jeffrey Getman
Principal

Melanie Bernardi
School Nurse

Parent/Guardian: New York State Law (chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, &10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete the section below and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started school, ask your dentist to fill out the section below. Return the completed form to the school nurse as soon as possible.

Last First Middle

Childs Name_____

Birth Date: _____ Sex:_____ Grade_____

TO BE COMPLETED BY THE DENTIST

Oral Health Status (check all that apply).

____ Yes ____ No Caries Experience/Restoration History – Has the child ever had a cavity (treated or untreated)? {A filing (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity}.

____ Yes ____ No Untreated Caries – Does this child have an open cavity? (At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present).

____Yes ____ No Dental Sealants Present

Other problems (Specify):_____

Optional Section – if you agree to release this information to your child's school, please initial here._____

Treatment Needs (check all that apply)

____No obvious problems. Routine dental care is recommended. Visit your dentist regularly.

____ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

____Immediate dental care required. Please schedule an appointment immediately with your dentist to avoid problems.

Dentist's name and address (please print or stamp) **Dentist's Signature**

_____ _____