☐

Have your Dentist fill out and return to your School Nurse at:
healthservices@hbgsd.us or Fax: 717-703-4333 or 717-703-4040

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT OF A STUDENT OF SCHOOL AGE

NAME OF CHILD'S SCHOOL_____ **BIRTHDATE**_____

NAME OF CHILD: Last First Middle	AGE	SEX ☐ M ☐ F	GRADE	SECTION/ROOM

No. and Street City State Zip

REPORT OF EXAMINATION: Use 'd' and 'D' for Primary and Secondary Teeth with Decay

TOOTH CHART

	RIGHT								**LEFT**								
Circle Existing UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
Circle Existing LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
Decay: (d, D) UPPER																	Upper
Decay: (d, D) LOWER																	Lower

Treatment completed today:_____

- **Is All Treatment Complete?** **Yes** ☐ **No** ☐

If No:

- **Tooth Numbers needing Fillings:** _____
- **Referral To Specialist:** _____

_____
Date of Dental Examination

x _____
Signature of Dental Examiner

x _____
Print Name of Dental Examiner

_____
Address Stamp for Practice

_____
Office Phone Number