CHAMBERSBURG AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES
MANDATED DENTAL EXAMINATION
FOR GRADES K/Original entry, 3 AND 7.

Re: Mandated Dental Form

For: _____ Grade:_____

The Pennsylvania Department of Health requires that every child entering school for the first time (kindergarten/original entry) and grades 3 and 7 have a dental examination. Because of your dentist's knowledge of your child's dental history, we recommend that your dentist do your child's exam. **If your child is examined by your family dentist, please have the dentist fill out the attached form and return to the school nurse.**

If you prefer, your child may receive a dental exam by the school dental hygienist at no cost to your family. The school dental exams are scheduled from November through May. Contact Melinda Ocker, RDH, PHDHP at 717-729-4759 for questions regarding the no cost dental exam.

Please check your dental screening preference below, sign and return to school nurse

I want my child to get a dental examination from the school dental hygienist.
Check one: Yes _____ No _____ (Checking yes and signing below gives your permission for the school dental hygienist to perform the mandated dental exams in all required grades - kindergarten, 3rd and 7th for which there is no private dental exam report on file. This permission may be revoked at any time by sending a signed note to the school nurse stating that you no longer desire the school dental professional to perform the exams.)

OR

I request the dental exam be done by my family dentist and have an appointment scheduled for _____(date).
I have detached and will return the family dentist report with my dentist's signature to the school nurse.

Parent/Guardian signature _____ Date: _____

----------**detach and return if private dentist doing exam**----------

CHAMBERSBURG AREA SCHOOL DISTRICT
Family Dentist Report

Name_____ Birthdate_____ Grade_____
Last First MI

The above named child last visited my office on_____ (DATE).

Currently, all necessary dental corrections have been made. Yes_____ No_____

If the answer is **NO**, fill in the following:

This child is in need of treatment for one or more of the following: Fillings_____ Extractions_____

Other/comments_____

This child is currently under treatment. Yes_____ No _____

Date submitted_____ **Dentist's signature**_____
Office address: