BERMUDIAN SPRINGS SCHOOL DISTRICT

DENTAL EXAM NOTICE

Dear Parents/Guardians:

The Pennsylvania School Health Code requires each student entering Kindergarten, Third, and Seventh Grade have a dental examination done by a dentist. At this time, we have not received a completed dental form for your child. All Dental exams must be completed and turned into school by December 31.

If you have not done so already, please call and schedule an appointment with your family dentist. Some dental offices may have long waits to schedule appointment times for exams.

Please have your family dentist complete the attached form and return it to school. The completed form may also be faxed to the school directly from your dentist.

Thank You.

AVISO DE EXAMEN DENTAL

Estimados Padres/Guardianes:

El Código de Salud Escolar de Pennsylvania exige que cada alumno que ingrese al jardín de infantes, tercero y séptimo grado tenga un examen dental realizado por un dentista. En este momento, no hemos recibido un formulario dental completo para su hijo. Todos los exámenes dentales deben completarse y entregarse a la escuela antes del 31 de diciembre.

Si aún no lo ha hecho, llame y programe una cita con su dentista familiar. Algunas oficinas dentales pueden tener largas esperas para programar los horarios de las citas para los exámenes.

Haga que su dentista familiar complete el formulario adjunto y devuélvelo a la escuela. El formulario completo también puede ser enviado por fax a la escuela directamente de su dentista.

Gracias.

Commonwealth of Pennsylvania
Department of Health
Dental Health

Family Dentist Report

Kindergarten, Third and Seventh Grade

Bermudian Springs School District
7335 Carlisle Pike
York Springs, PA 17372-8807

Phone Number 717-528-4113 or 717-624-4231
Elementary School Fax: 528-4007
Middle School Fax: 528-0034

_____
Student's Last Name First Name Middle Initial

_____
Student's Home Address

_____ **Please Circle**: Male or Female
Student's Date of Birth

_____ _____
Teacher's Name Grade

The above named child last visited my office on _____.
Month/Day/Year

Currently all the necessary dental corrections have been made. **Please Circle**: Yes or No

If the answer is no, please explain in the following:

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

Primary Teeth Fillings_____ Extractions_____
Permanent Teeth Fillings_____ Extractions_____

Disease of the supporting tissues_____

Gross malocclusion which is producing a facial deformity or is interfering with function:
_____

Cleft Palate and/or Cleft Lip_____other congenital malformation
_____

Prosthetic replacements for lost or missing teeth:
_____

The child is currently under treatment. **Please Circle**: Yes or No

_____
Dentist Signature **Print Dentist Name** **Date**

_____
Address City Zip/State