

Manheim Central School District
COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH
DENTAL HEALTH

Family Dentist Report

Name of Child (Last)	(First)	(Middle)	School	Grade	Age	Gender
						M <input type="checkbox"/> F <input type="checkbox"/>
Home Address			Parent			

The above named child last visited my office on _____ (list date).

At that time all necessary dental corrections had been made. Yes No

If the answer is No fill in the following:

This child is currently under treatment Yes No

Has patient received Topical F Applications? Yes Date _____ No

Date Submitted _____ Signature _____ DDS

Parent: Return this report to your child's school after dental examination has been completed and the report has been signed by the family dentist.