Danville Area School District

Student Health Services

Danville Senior High School
St Joseph's Elementary
St Cyril´s Kindergarten
Carla Raup, MHA, BS, RN, CSN
570-271-3268 ext 1103
Fax # 866-240-4318

Danville Middle School
Homeschool
Abbie Blasick, BSN, RN, CSN
570-271-3268 ext 3804
Fax # 866-283-7030

Liberty Valley Intermediate
Abbie Blasick, BSN, RN, CSN
Ruth Hosterman, LPN
570-271-3268 ext 3414
Fax # 866-428-5112

Danville Primary School
Carla Raup, MHA, BS, RN, CSN
Jess Petersen, LPN
570-271-3268 ext 2108
Fax # 866 -274- 6209

Dear Parent/Guardian,

Pennsylvania law requires children attending school to receive a dental examination in the year prior to or during **kindergarten**, third, and seventh grades. These grades were selected because they represent a critical period of growth and development in your child's life.

Because your family dentist can best evaluate your child's health and assist you in obtaining necessary treatments and corrections, we are recommending they complete the examination. Payment for the examination is the responsibility of the parent. We are sending the form, on the reverse side, home at this time to allow you the opportunity to have the examination completed any time before **November 30, 2026.** Please return this form to your child's school nurse when it is completed. Thank you for your assistance.

Sincerely,

Danville School Nurses

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Private Dental Form

Required for Kdg or year of enrollment, 3rd, & 7th grades

Name of Child _____ Date of Birth _____

Home Address _____ Sex: M _____ F _____

The above name child visited my office on (Date) _____

At that time all necessary dental corrections have been made: Yes _____ No_____

If No, fill in the following:

This child is in need of the following treatment:

Primary teeth ..... Fillings _____ Extractions _____

Permanent teeth ..... Fillings _____ Extractions _____

Diseases of the supporting tissue _____

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

Cleft Palate and/or cleft lip _____ Other congenital malformations _____

Prosthetic replacements for lost or missing teeth _____

Topical Fluoride applications ..... Yes _____ No _____

This child is currently under treatment.... Yes _____ No _____

Signature _____ D.M.D./D.D.S

Address _____

Date Submitted _____