PORT *WASHINGTON*
Union Free School District

KATHLEEN A. MOONEY, Ed.D. 516-767-5005
Superintendent

DENTAL HEALTH REPORT

Student's Name_____ Exam Date _____

School_____ Grade _____

This is to certify that the student named above:

☐ Has been examined and does not need treatment

☐ Is under my care for dental treatment

☐ Dental Treatment is complete

☐ Is orthodontia recommended: Yes☐ No☐

☐ Is child receiving orthodontia*: Yes☐ No☐

If orthodontic treatment will require an over the counter pain reliever to be given during school hours, please see medical forms section from our website for necessary paperwork or attach doctor's orders with dosage and frequency.

Dentist's Name _____

Dentist's Signature_____

Phone_____

Address_____

_____

Return this report to your child's school medical office