School District of Fort Atkinson

Dental Examination

Date_______________

Student Name______________________________________ Birth Date________________

School_________________________ Teacher________________________ Grade_______

To Parent or Guardian :
Please present this form to your child's dentist during your child's exam.

To Dentist: Please sign and date this form after the examination and return it to the patient's parent or guardian.

☐ Normal dental examination

☐ Next dental examination due in 6 months

☐ Other ____

☐ Abnormal dental examination

Comments____

Dentist Signature___________________________________ Date____________________