GLENMUIR HIGH SCHOOL

DENTAL EXAMINATION RECORD

STUDENT INFORMATION

NAME _____
LAST FIRST MIDDLE

ADDRESS _____
STREET OR DISTRICT POST OFFICE PARISH

SEX: M ☐ F ☐ **D.O. B.** ____ /_____ /_____ **AGE**:_____ **ACADEMIC YEAR** _____

TO THE PARENT/GUARDIAN:

Please arrange with your family Dentist or clinic for your child/ward to have a dental examination and possible correction or treatment. Take this form with and have it completed by the Dentist or Dental Nurse.

TO THE DENTIST OR DENTAL HYGIENIST:

Will you please make an oral examination of the above-named child and check "Yes" or "No" at the conditions where are so found to be need of dental care. It is desirable that arrangements be made for necessary correction or treatment.

The child needs professional care for the following:

CARIOUS TEETH	YES	NO	PERIODONTAL DISEASE	YES	NO
Primary			Gingivitis		
Permanent			Periodontitis		
			Occlusion		
			Fractured Dentures		

OTHER REMARKS

_____

_____

_____

_____

_____

NAME: _____ **SIGNATURE:** _____
Dentist / Dental Hygienist

DATE:_____

CLINIC/DENTAL OFFICE: _____

ADDRESS:_____

TELEPHONE NUMBER;_____

KINDLY AFFIX OFFICIAL STAMP