# TALAWANDA SCHOOL DISTRICT

## Dental Examination Report

Student Name: _____ Birth Date: _____

Address: _____ Phone No.: _____

_____

Parent or Guardian's Name: _____

School: ☐ Kramer Elementary School ☐ Marshall Elementary School

This is to certify that I have examined and found the condition checked below:

_____ 1. No dental defects.

_____ 2. Dental defects were completely treated.

_____ 3. Treatment has been started

_____ 4. Treatment is needed -- no treatment started.

Dentist Signature: Date:

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|---|---|
| | |

Parent/Guardian Signature: Date:

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