



School Dental Referral Form

Name _____

Address _____

School _____

Grade _____ Date _____

TO THE PARENTS:

Our school has a health program that is designed to improve, protect and promote the health of each child. As part of this health program we strongly urge you to take your child to a dentist of your choice at least twice a year for a dental examination and whatever treatment may be necessary. When the examination and treatment are completed, this form will be returned to school.

TO THE DENTIST:

Check one of the following statements before signing this card:

- Teeth were found in satisfactory condition
- All necessary dental work has been completed.

Signature of Dentist _____ Date _____