Dental Health Form

A new complete Dental Exam is required each academic year for both day and residential students

This will certify that ________________________________________________

Student Name

Son/daughter/ward of ____________________________________________

Parent/Guardian Name

was last examined by me on ______________________________________

Date

(    ) He/she has had all dental work done that is necessary at this time and his/her dental health is good.

(    ) He/she is receiving dental care from this office.

(    ) He/she has a condition which may need attention, and we note or recommend the following:

___________________________________________________________________________

Dentist Signature ___________________________ Date ______________

Office Phone __________________________________________

Office Address __________________________________________

Submit to: (Parent - underline correct destination)
Landmark EMS Health Center, PO Box 1489, Manchester, MA 01944/FAX 978-236-3103/EMSnurse@landmarkschool.org
OR
Landmark HS Health Center, PO Box 227, Prides Crossing, MA 01965/FAX 978-232-9546/HSmedicalforms@landmarkschool.org