LANDMARK SCHOOL

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:
Landmark HS Health Center
P.O. Box 227
Prides Crossing, MA 01965
FAX 978-232-9546