BERLIN BROTHERSVALLEY SCHOOL DISTRICT

Dear Parent(s) or Guardian(s):

According to the Pennsylvania School Code all children upon original entry into school, *grade three*, and *grade seven* must have a dental examination. These grades were selected because they represent critical periods of dental development in a child's life.

I recommend these examinations be done by your child's family dentist as he can best evaluate your child's dental needs since he is familiar with your child's dental history and can make recommendations, corrections, provide the appropriate dental prophylaxis, and refer if necessary. The attached form is to be completed by the examining dentist and returned to me by October 1. The payment for this examination is the responsibility of the parent.

If you request that your child's dental examination be done in school, please sing consent on the form below and return to me. School dental examinations will be completed by our School Dentist, Dr. Peter C. Jacobson, D.M.D.

Please complete the form below and return directly to me as soon as possible. Thank you for your cooperation.

Sincerely,

RR Ritchey MSN, RN, CSN

Roxanna Ritchey, MSN, RN, CSN

Certified School Nurse

Students Name_____ Grade_____

____I prefer to have my child examined by his dentist, privately. I understand I will be responsible for the payment for this examination. **I will return the attached dental examination form signed by his/her dentist to the school nurse by October 1.**

____I prefer to have my child's dental examination done in school. I will be notified of any abnormal findings.

_____

Parent or Guardian Signature

_____

Date

H514.027 (08/2011-under review)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20 ___

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
Last First Middle		☐ M ☐ F		

ADDRESS

No. and Street City or Post Office Borough/Township County State Zip

REPORT OF EXAMINATION

TOOTH CHART

	RIGHT								LEFT								
UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____
Signature of Dental Examiner

_____
Print Name of Dental Examiner

_____
Address