

WALLINGFORD SWARTHMORE

SCHOOL DISTRICT

101 PLUSH MILL ROAD, WALLINGFORD, PA 19086-6334

DUE WITHIN 30 DAYS OF BEGINNING SCHOOL FOR GRADES, K, 3 AND 7 AND ALL STUDENTS NEW TO PENNSYLVANIA SCHOOLS

PRIVATE DENTIST REPORT

LAST NAME _____ FIRST _____ INITIAL _____

DOB ____/____/____ GRADE _____ SCHOOL _____

The above-name child last visited my office on ____/____/____.

At that time, all necessary dental corrections had been made YES NO

As of ____/____/____, has received topical fluoride application YES NO

PLEASE COMPLETE THE FORM BELOW

The child is in need of treatment for one or more of the following:

Primary teeth fillings extractions
Permanent teeth fillings extractions

Diseases of the supporting tissues

Gross malocclusion, which is producing a facial deformity or is interfering with function

Cleft palate and/or cleft lip YES NO

Other congenital malformations (specify)

Prosthetic replacements for lost or missing teeth YES NO

The child is currently under treatment YES NO

Signature _____

Address _____

(_____) _____
Phone

City, State, Zip