# North Cape School District
# Student Dental Examination

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Last | First | Middle | Grade |

| _____ | _____ | _____ |
|---|---|---|
| Street Address | City & State | Zip Code |

As part of our school health program, we suggest you take your child to your dentist for an examination and necessary care. **This examination is not required by the school district. It is recommended and voluntary. There is no penalty for non-compliance.**

**Dentist: Check one of the following statements before signing this report:**

_____ No dental work necessary
_____ All immediately dental work has been completed
_____ Other (Specify below)

_____
_____
_____
_____

Comments:
_____
_____

Examination Site _____

| _____ | _____ |
|---|---|
| Signature of Physician | Date |

Note: Please return this form to school after the examination is completed.