OUR LADY OF VICTORY SCHOOL
Dental Health Record

Date: _____/_____/_____

Name of Student: _____

Date of Birth: _____/_____/_____ Grade: _____

School Nurse: Mrs. Kelley Wood, R.N.

Please take this form to your family dentist when your child has his next dental appointment. Have your dentist complete the form and have your child return the form to the school nurse.

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REPORT OF DENTAL EXAMINATION:

A. _____ No dental treatment is necessary.
B. _____ All necessary dental treatment has been completed.
C. _____ Treatment is in progress.

Further recommendations: _____

_____

Date: _____/_____/_____

Dentist's Signature: _____

Dentist's Name (Please Print): _____

Address: _____

Phone Number: _____