## Crestwood School District Dental Examination Permission

completed within one year prior to the student's entry into kindergarten/ first, third or seventh grade, provided they are completed on the form furnished by the school. If the dental examination is to be completed by a family dentist, the form must be returned before May 1.  You may be present during the school examination. If you desire to be present, contact the school nurse for a date and time.  The Mobile Dentist is a program that provides dental care and is an additional program open to all students. A separate form to complete will follow.			
The laws of Pennsylvania require a dental exam upon entry into kindergarten/first, third, and seventh grades. This dental examination may done by the school's dentist at no expense to you <u>OR</u> by your family deat your own expense.  Please check one of the following and return to the school tomorrow. I want my child examined by the school dentist.  I will have my child examined by my family dentist.  Please note: The district will accept reports of private dental exams completed within one year prior to the student's entry into kindergarten/first, third or seventh grade, provided they are completed on the form furnished by the school. If the dental examination is to be completed by family dentist, the form must be returned before <u>May 1.</u> You may be present during the school examination. If you desire to be present, contact the school nurse for a date and time.  The Mobile Dentist is a program that provides dental care and is an additional program open to all students. A separate form to complete will follow.	(Student's Name)	(Grade)	(Teacher)
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(Date)	(Signature of Parent/Guardian)		(Date)

H514.027

## COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HEALTH

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

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NAME OF CHILD								AGE SEX				Ī	GRADE		SECTION/ROOM				
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No.	and Street		***************************************	Cil	v or Po	st Offic	•	Por	ough or	Towns	L. S			T		<del></del>		***************************************	
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***************************************	LOWER																	Lower	
reatment Completed									•	Yes □					No □				
	Date of	Denta	l Exar	ninatio	on														
Signature of Dental Examiner							***************************************		dengamaka	Print Name of Dental Examiner									

Address