Manheim Central School District
COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH
DENTAL HEALTH

Family Dentist Report

Name of Child (Last) (First) (Middle)	School	Grade	Age	Gender M ☐ F ☐
Home Address	Parent			

The above named child last visited my office on . . . . . (list date).

At that time all necessary dental corrections had been made. Yes ☐ No ☐
If the answer is No fill in the following:
This child is currently under treatment Yes ☐ No ☐

Has patient received Topical F Applications? Yes ☐ Date _____ No ☐

Date Submitted _____ Signature _____ DDS

***Parent*: Return this report to your child's school after dental examination has been completed and the report has been signed by the family dentist.**