OCEANPORT SCHOOL DISTRICT
Oceanport, New Jersey

DENTAL REPORT FORM

Student's Name _____ Grade _____

Please return form to the school nurse when completed:

Report of Dental Examination:

_____ Examination date.
_____ All necessary dental treatment is completed.
_____ Partial treatment has been given.
_____ Further dental treatment is needed.
_____ Next scheduled dental appointment.
_____ Orthodontic treatment may be needed.
_____ Student is receiving orthodontic treatment.

_____
Signature of Dentist

_____
Name of Dentist

_____
Address

_____
Telephone #

_____
Signature of Parent/Guardian