



OFFICE OF THE SCHOOL NURSE
River View Local School District

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To assure that your child has a healthy start in school, a dental check-up is **encouraged**. When your child has this check-up, please have the examiner complete this form and return it to school.

STUDENT _____ DATE OF BIRTH _____
Last first middle initial

DATE OF EXAM: _____

The following services have been performed:

- _____ Examination
- _____ Radiographics
- _____ Oral Prophylaxis
- _____ Fluoride Treatment
- _____ Sealants
- _____ Restorations

The following oral hygiene instruction was provided:

- _____ Tooth brushing
- _____ Flossing
- _____ Diet counseling reflecting relation of diet to dental health
- _____ Home/school use of fluoride

The following statements apply:

- _____ All necessary services have been performed.
- _____ No restorative services are required at this time.
- _____ Further treatment is indicated.
- _____ Future appointments have been arranged.

Comments: _____

Office Name and Stamp Here
(or complete information below) →

Signature of Examining Dentist Date

Printed Name of Dentist Telephone Number FAX

Street Address City State Zip Code