Oceanport School District
DENTAL REPORT FORM

Student _____ Grade _____

Please return form to the school nurse when completed:

Report of Dental Examination:

_____ Most recent 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 Parent/Guardian

_____
Signature of Dentist

_____
Print Name of Dentist

_____
Address

_____
Telephone Number

Rev. 8/3/2021