SALISBURY TOWNSHIP SCHOOL DISTRICT

FAMILY DENTAL FORM

Date: Grade:	Date: Grade:
Patient's Name:	Patient's Name (please print)
Homeroom Teacher:	Homeroom Teacher:
Under Care?YesNo	Under Care?YesNo
Necessary care completed?YesNo	Necessary care completed?YesNo
Topical Fluoride Application?YesNo	Topical Fluoride Application?YesNo
Dentist's Name:	Dentist's Name:
Dentist Signature	Dentist Signature
PLEASE RETURN THIS FORM TO SCHOOL	***PLEASE RETURN THIS FORM TO SCHOOL**

SALISBURY TOWNSHIP SCHOOL DISTRICT

FAMILY DENTAL FORM

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