COLUMBIA BOROUGH SCHOOL DISTRICT
200 North Fifth Street, Columbia, PA 17512
Phone: 717-684-2283 • Fax: 717-681-2617

"Dedicated to Excellence…"

www.columbiabsd.org

SCHOOL NAME (CHS, CMS Hill, CMS Taylor, Park) _____ **SCHOOL YEAR** _____

Dear Parents or Legal Guardians:

The **STATE OF PENNSYLVANIA requires** that students receive a dental exam upon:
1) entering first grade 2) entering third grade 3) upon entering seventh grade

This exam must be completed within one year before the start of school**. Any exam done after August 22, 2018, will meet the requirements**.

Your family dentist can best evaluate your student's teeth, provide a more extensive examination, and assist you in determining any necessary treatment or correction. We encourage parents to schedule appointments with their family dentist.

You will find two enclosed forms for your use. The separate form, **FAMILY DENTIST REPORT**, is to be used when your child is seen by your family dentist for a regular check-up. Upon completion of this exam, please return the form to your child's school nurse. If you do not have a dentist, a school dental screening done by the school dental hygienist will be necessary to meet state requirements. In this case, please sign the bottom permission slip, **SCHOOL DENTAL HYGIENE SCREENING**, authorizing the school dental hygienist to conduct the screening and return the slip to your child's school nurse.

Sincerely,

—Nursing Team, CBSD

SCHOOL DENTAL HYGIENE SCREENING PERMISSION SLIP

_____**Yes**, I approve the dental screening of my child _____ _____
Child's Name Grade

_____**Yes**, I approve a professional dental cleaning for my child _____ _____
Child's Name Grade

_____**No**, I do not approve the dental screening of my child _____ _____
Child's Name Grade

Does your child need an antibiotic before dental work? Yes No

Would you like your child to have fluoride varnish applied to their teeth? Yes No

_____ _____
Parent or Guardian's Signature Date

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PLEASE RETURN ASAP TO YOUR SCHOOL NURSE
COLUMBIA BOROUGH SCHOOL DISTRICT
FAMILY DENTIST REPORT

_____ visited my office _____
(Child's Name, Grade, and Date) (Name of Dentist Office)

At that time, the following services were provided: _____ Prophy _____Exam _____X-rays _____Fluoride _____ Sealants _____Fillings _____Extractions _____Ortho

In addition, the following developmental problem was found _____

_____

_____

_____
Dentist Signature

_____
Dentist Name Printed

_____
Address

_____
Phone number with area code

I hereby give permission for the representatives of the above-named dental office to release this dental information to the Columbia Borough School District Nurses Department for the above-named student.

_____ __ / __ / ____
Signature of Parent/Guardian Date

PLEASE CHECK SCHOOL NAME

_____CHS _____ CMS Hill Campus _____ CMS Taylor Campus _____ Park Elementary