Monroe-Woodbury Central School District
Proof of Dental Examination

To be completed by the parent (please print):

Student's Name: **Last** **First** **Middle**			**Birth Date:**
Address: **Street** **City** **ZIP Code**			**Telephone:**
Name of School:		**Gender:**	**Grade:**
Parent or Guardian Signature:		**Print Name:**	

To be completed by dentist:

Oral Health Status (check all that apply)

□ **Yes** □ **No** **Dental Sealants Present**

□ **Yes** □ **No** **Caries Experience / Restoration History** _____

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□ **Yes** □ **No** **Untreated Caries** _____

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□ **Yes** □ **No** **Malocclusion** _____

Treatment Needs (check all that apply):

□ **Urgent Treatment-** abscess, nerve exposure, advanced disease state, signs/symptoms of pain, swelling or infection

□ **Restorative Care –** amalgams, composites, crowns, etc.

□ **Preventive Care –** sealants, fluoride treatments, prophylaxis

□ **Other** – periodontal, orthodontic

Please note _____

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Signature of Dentist _____ **Date** _____

Name _____

Address _____**Telephone**_____