52473 State Road 933 | South Bend, Indiana 46637-3894 | (574)272-3922 | school.christthekingonline.org

Certificate of Dental Examination

Please Print

Name: _______________________________________ Date of Birth ____/____/_______

Parent/Guardian: ____

School: ____

To Be Completed by your Dentist

Dental Examination

Code: No Defect = 0 Defect = Note Condition

1. Teeth
    a. Cavities ____
    b. Malocclusion ____
    c. Soft Tissue ____
    d. Oral Hygiene ____
2. Present Status
    a. Does the patient presently have any tooth decay or other dental defects which may reduce his/her efficiency or prevent him/her from receiving the full benefit of his/her school work?
    b. If yes, please explain: ____
    ____
3. Recommendations

    ____

    ____

Physician completing this form: ____

Please Print/Stamp

Physician's Signature: ____________________________________ Date: ___/___/______