SOUTHERN LEHIGH SCHOOL DISTRICT
School Health Services

Family Dentist Report

Student's Name _____

Address _____

School _____ Homeroom _____

The above name child last visited my office on _____
Date

At that time, all necessary dental corrections had been made.

Yes_____ No_____

- If the answer if NO, please complete the following:

1. Primary teeth Fillings_____ Extractions_____
2. Permanent teeth Fillings_____ Extractions_____
3. Diseases of supporting tissues_____
4. Gross malocclusion producing facial deformity or interfering with function
   _____
5. Cleft palate_____ Cleft lip_____ Other congenital malformations_____
6. Prosthetic replacements for missing teeth_____

- This child is currently under treatment. Yes_____ No_____

DDS
Signature _____DMD

Address _____

_____

Date signed_____

Please return to: Donna Atkinson, School Nurse
Lower Milford Elementary School
7350 Elementary Road
Coopersburg, PA 18036

ST. MICHAEL THE ARCHANGEL SCHOOL
5040 ST. JOSEPH ROAD
COOPERSBURG, PA 18036