R.I. DEPARTMENT OF EDUCATION

REPORT OF SCHOOL DENTAL EXAMINATION

This is to certify that I have examined the teeth of

_____ _____
Name Grade

- ☐ No dental treatment is necessary.
- ☐ Treatment has been recommended.
- ☐ Treatment is in progress.
- ☐ Treatment completed.

Further recommendations or comments: _____

_____

_____ _____
Date Signature of Family Dentist

PLEASE RETURN THIS CARD TO THE TEACHER WITHIN 60 DAYS OR

BEFORE _____
Date

S. H. 21 '71
(over)