COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL														DA	TE	20		
NAME OF CHILD										AG	E	SEX			GRADE		SECTION/ROOM	
Last				First Middle									M F					
ADDRESS			***************************************						<u></u>	····						<u> </u>		
No. and Street City or Post Office Borough or Tox									or Towns	ship Cou			unty State				Zip	
REPORT OF EXAMINATION														-				
		RIGHT TOOTH CHA							CHAF	RT LEFT								
UPPER		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Upper
LOWER		32	31	30	29	B 28	27	D 26	25	F 24	G 23	22	21	ا 20	19	18	17	Lower
	UPPER				T	S	R	Q	P	0_	N	M	L	К				Upper
<u> </u>	LOWER																	Lower
Is The Child Under Treatment									Yes □ No □						No C			
Treatment Completed						\.							Yes □			No 🗔		
	Date		ntal Ex	amina	tion		F-Min-											
		,																
Signature of Dental/Examiner								***************************************						Print I	Name o	of Dent	al Exar	miner

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Address