



State Required Dental Exam

Please return form to: Susquehanna Waldorf School, 15 West Walnut St. Marietta PA 17547
Phone: (717) 426-4506 Fax: (717) 426-3326

Dear Parents:

The State of Pennsylvania requires all school age children to have periodic *dental* examinations as follows: school entry in kindergarten or grade one, grade three, and grade seven. Transfer students, as well as students with incomplete health records, shall be required to have a dental examination.

As a result of our discussions with the school dentist, we feel a family dentist can best evaluate a child's teeth, provide a more extensive examination, and assist you in obtaining any necessary treatment or correction.

The family dentist's examination of your child may be done during the summer or any time before *September 30*, using the form on the back of this letter. The family dentist's examination is done at your expense. Students not returning the completed form and this letter by *September 30* will automatically be examined by the school dentist.

If you prefer, the school will provide a school dentist's examination of your child at school district expense. This letter must be returned by *September 30*.

Please contact your school nurse with any questions.

CHECK ONE

_____ My family dentist has examined my child and completed the form on the back of this letter.

_____ I prefer the school dentist examine my child.

Student's Name

School/Grade/Teacher

Parent's Signature

Date

Commonwealth of Pennsylvania
 Department of Health
 Dental Health

SCHOOL DENTAL
 REFERRAL FORM

DONEGAL SCHOOL DISTRICT	GRADE	DATE
Patient's Name	Address	
<input type="checkbox"/> Has Been Referred To Your Office for Examination and Treatment		<input type="checkbox"/> Has Been Inspected in School and Referred to Your Office for Treatment
CHECK CLASSIFICATION BELOW		

EXAMINATION OR INSPECTION FINDINGS (PATIENT CLASSIFICATION)

- CLASS 1 PATIENT WITH FAMILY DENTIST
 CLASS 2 DENTAL HYGIENE SERVICE PATIENT
 CLASS 3 TREATMENT PATIENT
 CLASS 4 SPECIAL PROBLEM

HAS PATIENT RECEIVED TOPICAL FLOURIDE APPLICATIONS? _____ YES, DATE _____ NO _____

IS PATIENT UNDER TREATMENT? _____ ARE NECESSARY CORRECTIONS COMPLETED? _____

SIGNATURE OF DENTIST _____ DDS

SIGNATURE OF PARENT _____

DATE _____

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PATIENT CLASSIFICATION

- CLASS 1 Patient under care of a family dentist.
- CLASS 2 School dental hygiene service patient. (No urgent or extensive treatment requirements, but having newly erupted permanent teeth; recommended for preventive program.)
- CLASS 3 Treatment patient (needing dental care requiring referral to family dentist or community clinic.)
- CLASS 4 Special problem (having dental problem requiring specialized care; example, dentofacial deformity or handicapping condition).