Donegal School District

Administrative Office
1051 Koser Road
Mount Joy, PA 17552
(717) 653-1447 Fax (717) 492-1350

Dear Parent/Guardian:

The State of Pennsylvania requires all school age children to have periodic dental examinations as follows: **28 PA Code 23.3(a)* states Dental Examinations shall be required on original entry into school and in grades three and 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 completed during the summer or any time within one year prior to the start of the school year, using the form on the back of this letter. The family dentist's examination is done at your expense.

If you prefer, the school will provide a school dentist's examination of your child at the school district's expense. Your consent is required for the school examination to be performed. The school nurse will be present for all examinations. You are also invited to be present during your child's exam.

Please contact your school nurse with any questions.

DHS: 492-1212 **DJH:** 928-2912
DIS: 426-2552 **DPS:** 492-1330

Please check one:

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

_____ I prefer that the school dentist examine my child.

_____ I would like to be present for the school dental exam.

_____ _____

Student's Name Grade

_____ _____

Parent's Signature Date

H514.027 (08/2011-under review)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____ 20 ___

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
Last First Middle		☐ M ☐ F		

ADDRESS

No. and Street City or Post Office Borough/Township County State Zip

REPORT OF EXAMINATION

TOOTH CHART

	RIGHT								LEFT								
UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____ _____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address