Dental Health Form

A new complete Dental Exam is required each academic year for both day and residential students

This will certify that_____
Student Name

Son/daughter/ward of_____
Parent/Guardian Name

was last examined by me on_____
Date

( ) He/she has had all dental work done that is necessary at this time and his/her dental health is good.

( ) He/she is receiving dental care from this office.

( ) He/she has a condition which may need attention, and we note or recommend the following:

_____

Dentist Signature_____ **Date**_____

Office Phone_____

Office Address_____

_____

To Parents/Guardians: Please submit completed form via mail or fax if you are unable to upload this form online to your student's Enrollment Packet:

Landmark Medical Forms, PO Box 227, Prides Crossing, MA 01965 FAX 978-921-0361