

**Manheim Central School District**  
**COMMONWEALTH OF PENNSYLVANIA**  
**DEPARTMENT OF HEALTH**  
**DENTAL HEALTH**

**Family Dentist Report**

Name of Child (Last)	(First)	(Middle)	School	Grade	Age	Gender M <input type="checkbox"/> F <input type="checkbox"/>
Home Address			Parent			

The above named child last visited my office on ..... (list date).

At that time all necessary dental corrections had been made. Yes  No

If the answer is No fill in the following:

This child is currently under treatment Yes  No

Has patient received Topical F Applications? Yes  Date \_\_\_\_\_ No

Date Submitted \_\_\_\_\_ Signature \_\_\_\_\_ DDS

***Parent: Return this report to your child's school after dental examination has been completed and the report has been signed by the family dentist.***