St. Charles Borromeo Catholic School
4910 Trier Rd. **Ft. Wayne, IN 46815** **260-484-3392**
schooloffice@stcharlesschoolfw.org **www.stcharlesschoolfw.org**

DENTAL EXAMINATION

PLEASE PRINT

Student's Name: ____
(Last) (First) (MI)

Date of Birth: ____/____/____ Enrolling in Grade ______________

This Form is to be Completed by the Child's Dentist.

DENTAL EXAMINATION
Code: No Defect = 0 Defect = Note Condition

TEETH

1. Cavities ____
2. Malocclusion ____
3. Soft Tissue ____
4. Oral Hygiene ____
5. Fluoride ____
6. Sealant ____

PRESENT STATUS

Does this child presently have any tooth decay or other dental defects which may reduce his/her efficiency or prevent him/her from receiving the full benefit of his/her school work?
If yes, please explain ____
____

FURTHER RECOMMENDATIONS

____
____

____
Print/Stamp Dentist's Name Signature

____
Date