DENTAL REFERRAL FORM

WEST SALEM SCHOOL DISTRICT

Student Name:

____

Grade: ______________________ Date: _______________

To the Parents / Guardian:

Our school has a health program that is designed to improve, protect and promote the health of each child. As part of this health program we strongly urge you to take your child to a dentist of your choice at least once a year for a dental examination. When the examination is completed, return this form to the school.

To the Dentist:

Please sign this form upon the completion of the dental examination.

Signature of
Dentist:___________________________Date:____________

Return signed form to the office of the school nurse.