CAMDEN CITY SCHOOL DISTRICT

HEALTH SERVICES DEPARTMENT
201 N. Front Street, Camden, NJ 08102
Office: (856) 966-2180 ● Fax: (856) 536-3484

REPORT OF DENTAL SCREENING RESULTS

Site: ____

Date: ______________________

To the Parent/Guardian of: ____

Your child has been screened to determine his/her dental needs. The screening indicates:

______ 1. Your child's teeth have no readily apparent dental defects. However, it is recommended that your child visit the dentist for a complete dental examination and preventative services on a regular basis.

______ 2. Your child appears to need dental treatment. Please arrange an appointment with the dentist for a complete examination and any necessary treatment.

______ 3. Your child is in immediate need of dental care. Please arrange for a dental appointment as soon as possible so that further complications or pain can be avoided.

If you have any questions about the nature of your child's dental problems, please call the Nurse at: ____

Please have your dentist complete the form below. Tear it off and return the form to your child's teacher.

CERTIFICATE OF DENTAL TREATMENT

This is to certify that:____
(Child's Name)

___ 1. Does not need dental work at this time.

___ 2. Is currently under dental treatment.

___ 3. Has had all necessary dental work completed.

Further recommendation: ____

Sincerely,

___________________ _______

Signature of Dentist Date