EAST STROUDSBURG AREA SCHOOL DISTRICT

RE: Parent Request For Private Dental Exam

Name: _____ Date: _____

Home Room: _____ Grade: _____

Dear Parent/Guardian:

We have filed your request for a private dental exam in your child's records and have provided you with the required reporting form.

Please note that your dentist's office records can be used to complete the form if your child has had a recent exam, no more than one year prior to the opening of the school term.

For your convenience, you may have your dentist **fax** the report to your child's school to the attention of Karen Buis, RDH. Please be certain to complete the information in the top box before giving the form to your dentist.

Fax Numbers:

	(570)
J.M. HILL SCHOOL	476-0720
MIDDLE SMITHFIELD SCHOOL	223-2110
SMITHFIELD SCHOOL	476-0488
RESICA SCHOOL	223-2100
EAST STROUDSBURG ELEM.	420-8310
J.T. LAMBERT INTERMEDIATE	476-0464
EAST STROUDSBURG H.S. (S)	422-7841
BUSHKILL SCHOOL	588-4406
LEHMAN INTERMEDIATE	588-4411
EAST STROUDSBURG H.S. (N)	588-4421
NOTRE DAME H.S.	476-0629
NOTRE DAME ELEMENTARY	422-6935

ESASD Board Policy 209: *If a Parents/Guardians requests a private dental exam, they have until November 1of the applicable year to provide a private dental report. If a private report is not received by November 1, the parent/guardian will be notified in writing that their child will receive a screening at school at no cost to the parent(s).*

East Stroudsburg Area School District
East Stroudsburg, Pennsylvania 18301

Family Dental Report

RETURN TO SCHOOL DENTAL HYGIENIST

To be completed by parent before November 1 of current school year

_____ _____
(Name of Child) (Name of Teacher)

_____ _____
(Name of School) (Grade)

To be completed by dentist

1. This child last visited my office _____
(Date)

2. All necessary treatment was received at this time. ☐ Yes ☐ No

3. If the above answer is no, complete the following:

This child is in need of treatment for:

☐ Primary Teeth ☐ Fillings ☐ Extractions
☐ Permanent Teeth ☐ Fillings ☐ Extractions
☐ Mal-occlusion
☐ Prosthetic replacement for lost or missing teeth
☐ Other _____

This child is currently under my supervision for the above condition:

☐ Yes ☐ No

4. This child receives topical fluoride applications under my supervision:

☐ Yearly ☐ Every Six Months ☐ Never

_____ _____
(Print Name of Dentist) (Signature of Dentist)

_____
(Address)

_____

_____
(Date)

Note: If the child has been examined no earlier than one year prior to the opening of the school term for which the exam is being requested, the information may be supplied from office records. If the child has not been examined within one year of the opening of the school term, a new examination will be required.

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