SOUTH BEND COMMUNITY SCHOOL CORPORATION

Dental Examination (To be filled out by your Dentist)
Please return to the school nurse

Please Print

Name: ____________________________________ School: ____________________

Address: ____

Code: No Defect – 0
Defect – Note Condition

I. Teeth
Malocclusion: ____
Cavities: ____

II. Present Status
Restorations Completed: _______________________________________
Appointments Scheduled: ______________________________________

III. Orthodontic Care: ____

IV. Recommendations: ____
____

____
Dentist's Name (please print)

____
Dentist's Signature

Rev. 3/30/15 MV