MADISON PUBLIC SCHOOLS

Dentist's Examination Form for New Students

STUDENT'S NAME: _____

_____ Date of Examination

_____ All necessary dental treatment if complete

_____ Partial treatment has been given and is being continued as necessary

_____ Further dental treatment is needed

_____ Orthodontic treatment may be needed

_____ Student is now receiving orthodontic treatment

_____ _____

Signature of Dentist | Dentist's Name (Please Print)

_____ _____

Address | Telephone