SCHOOL HEALTH SERVICES
WAPPINGERS CENTRAL SCHOOL DISTRICT
_____SCHOOL

DENTAL HEALTH CERTIFICATE

Student _____

Date of Comprehensive Dental Examination: _____

No Treatment Required ____ Treatment in Progress ____ Treatment Completed ____

Student is in fit condition of dental health to permit school attendance: Yes ____ No ____

Signature of Dentist _____

Name of Dentist _____

Address of Dentist _____

_____

Telephone Number of Dentist _____