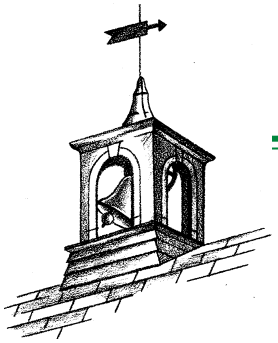

Donegal School District

Administrative Office
1051 Koser Road
Mount Joy, PA 17552
www.donegal.k12.pa.us

Dear Parent/Guardian:

The State of Pennsylvania requires all school age children to have periodic dental examinations as follows: **28 PA Code 23.3(a)* states Dental examinations shall be required on original entry into school and in grades three and seven.** Transfer students, as well as students with incomplete health records, shall be required to have a dental examination.

As a result of our discussions with the school dentist, we feel a family dentist can best evaluate a child's teeth, provide a more extensive examination, and assist you in obtaining any necessary treatment or correction.

The family dentist's examination of your child may be completed during the summer or any time within *one year prior to the start of the school year,* using the form on the back of this letter. The family dentist's examination is done at your expense.

If you prefer, the school will provide a school dentist's examination of your child at the school district's expense. *Your consent is required for the school examination to be performed.* The school nurse will be present for all examinations. You are also invited to be present during your child's exam.

Please return this letter by *September 30.* Please contact your school nurse with any questions.

DHS:	Donna Stadel	492-1212	fax: 492-1241		DPS:	Patti Boylston-Lytle	492-1330	fax: 492-1341
DIS:	Heidi Stewart	426-8086	fax: 426-2417		DJH:	Patti Boylston-Lytle	928-2912	fax: 928-2911

Please check one:

***The exam may be completed within *one year* prior to the start of the school year.

_____ My family dentist has examined my child and completed the form on the back of this letter.

_____ I prefer the school dentist examine my child.

_____ I would like to be present for the school dental exam.

_____ _____
Student's name Grade

_____ _____
Parent's signature Date

Rev 10/23/12

H514.027 (08/2011-under review)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20 ___

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
_____ Last First Middle		☐ M ☐ F		

ADDRESS

_____
No. and Street City or Post Office Borough/Township County State Zip

REPORT OF EXAMINATION

TOOTH CHART

	RIGHT								**LEFT**								
UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment? Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____ _____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address