MAYWOOD PUBLIC SCHOOLS

Dental Examination Report

CHILD'S NAME_____ **AGE**_____

GENERAL DENTAL CONDITION

_____

_____

_____

NUMBER OF CAVITIES_____

NUMBER OF FILLINGS_____

NUMBER OF EXTRACTIONS_____

CLINICAL EVIDENCE OF ABSCESS_____

RECOMMENDED DENTAL CARE

_____

_____

_____

_____ _____

EXAMINING DENTIST'S SIGNATURE **DATE**

_____

PLEASE PRINT NAME

_____

ADDRESS

_____ _____

PHONE NUMBER **PHYSICIAN'S STAMP**