



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