

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL 21<sup>st</sup> Century Cyber Charter School DATE \_\_\_\_\_ 20\_\_\_\_

NAME OF CHILD			AGE	SEX	GRADE	SECTION/ROOM
_____	_____	_____		<input type="checkbox"/> M <input type="checkbox"/> F		
Last First Middle						

ADDRESS

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

**REPORT OF EXAMINATION**

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