Our Lady of Mt. Carmel School
Office of the School Nurse
ph: 914-592-7575 x 108 *fax: 914-345-1591*

59 East Main Street
Elmsford, NY 10523

Dental Examination

Student _____ **Grade** _____

Date of Birth _____ **Gender** ___**M** ___ **F**

Dentist please complete the following information

	No treatment necessary
	Dental work completed
	Under treatment for:

Date of Examination: _____

Seen at the office of:
(Please stamp)

Dentist Signature _____

Parent Signature _____