# 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

_____
Date

Form 133102X rev. 4/15/15