

Mary McDowell Friends School
20 Bergen Street, Brooklyn, New York 11201 • (718) 625-3939

2011-2012 Academic Year

Dental Health Certificate

Section 1. To be completed by Parent or Guardian (Please Print)

Name of Child _____ Date of Birth _____
(please print)

Sex: M__ F__ Grade____ Will this be your child's first visit to a dentist? Yes__ No__

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? Yes__ No__

Section 2. To be completed by the Dentist

Student's Name _____ Date

Yes__ No__ The student listed above is in fit condition of dental health to permit his/her attendance to school.

Dentist's Name and address (Please print or stamp) _____ Date

The date of exam needs to be within 12 months of the start of the school year in which it is requested.

Dentist's Signature