# WEBER SCHOOL DISTRICT
# KINDERGARTEN
# Dental Exam (Recommended)

STUDENT'S NAME_____SCHOOL_____GRADE_____

ADDRESS_____City_____State_____Zip_____

PHONE_____

Dear Dentist:

Please fill in the following blanks:

| | | |
|---|---|---|
| Have all defects been corrected? | ☐ Yes | ☐ No |
| Is child receiving Fluoride Prophylaxis? | ☐ Yes | ☐ No |
| Is child's dentition development normal for age? | ☐ Yes | ☐ No |

_____D. D. S.

Date_____