School District of Menomonee Falls

Dental Examination Card

School: _____ Date: _____

This certifies that _____
(last name, first name of student)

has been examined by his/her dentist. The necessary dental work has been done.

Date of Examination: _____

Name of Dentist: _____ Signature of Dentist: _____
(please print)

Dentist Address: _____

Dentist Phone Number: _____