New York School for the Deaf

555 Knollwood Road, White Plain, New York 10603
Voice (914) 481-8241 * Fax (914) 681-1308

Dear Parents/Guardian:

The New York School for the Deaf requires that each student entering school for the first time have a dental examination. **We also recommend that all children have a yearly dental exam.**

Examinations are to be done by your family dentist or clinic. It is the responsibility of the parents/guardian to see that their children have their teeth in good condition at the time school opens, or that they are having the necessary dental work completed. Please return the completed form no later than the first day of school.

Thank you for your cooperation,

Maria Anzalone D'Ascoli, RN
914-481-8241
914-681-1308 (fax)

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Dentist's Report of Annual Dental Examination and Treatment

This is to certify that ____
(student's name)

( ) Had a dental exam

( ) Had all necessary dental work

( ) Is under dental treatment

( ) Is in need of dental work at this time

( ) Further recommendations ______________________________

____

______________________________ ______________ ______________
(signature of dentist) ***(date)*** ***(phone number)***

New York School for the Deaf

555 Knollwood Road, White Plain, New York 10603
Voice (914) 481-8241 * Fax (914) 681-1308

Estimados Padres/ Tutor:

La Escuela de Nueva York de los Sordos requiere que cada estudiante tenga un examen dental al ingresar a la escuela por primera vez. **También recomendamos que todos los niños tienen un examen dental anual.**

Los exámenes deben ser hechos por el dentista de la familia o en una clínica dental. Es la responsabilidad de los padres/tutor en ponerlos en tratamiento y/o mantener a sus niños en buena salud dental antes de comenzar la escuela. Por favor devuelve el formulario completado no mas tarde que el primer día de escuela.

Gracias por su cooperación,

Maria Anzalone D'Ascoli, RN
914-481-8241
914-681-1308 (fax)

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Dentist's Report of Annual Dental Examination and Treatment

This is to certify that ____
(student's name)

( ) Had a dental exam

( ) Had all necessary dental work

( ) Is under dental treatment

( ) Is in need of dental work at this time

( ) Further recommendations ______________________________________
____

______________________ ____________ ____________
(signature of dentist) ***(date)*** ***(phone number)***