Christ the Teacher Catholic School
Family Dentist Report

Student's Name _____ Date of Birth_____

Date of last visit _____

Is the child currently under treatment? Yes_____ No _____

Recommendations or Restrictions: _____

_____

Examiner's Signature _____ Date _____

Printed Name _____ Telephone _____

Address: _____

We understand that you may not be able to return this and/or the medical forms at the same time as your registration. Please return when you get both completed.