

Leyton Public Schools



DENTAL EXAM KINDERGARTEN ONLY

Student Name	Birthdate	Grade
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By signing below, the parent/guardian of _____
consents for the release of the health and medical information contained herein to be
released to Leyton Public Schools.

Signature of Parent/Guardian	Printed name/relationship to student	Date
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Dental Health

Caries: _____

Hygiene: _____

Comments: _____

Signature of Examiner	Date of Exam
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Name/Title of Examiner (please print or use stamp)