SPRINGFIELD

SCHOOL DISTRICT

District Administrative Office 200 South Rolling Road
Springfield, Pennsylvania 19064
Main: (610) 938-6000 • Fax: (610) 938-6005

Subject: Dental Screenings/Examination

Dear Parents / Guardians,

The Pennsylvania School Health Regulations require that students entering kindergarten or new enters into the first grade (those students who did not attend kindergarten in a public or parochial school in the state of Pennsylvania) and all students in the third and seventh grade are required to have a dental examination. This is NOT an orthodontic examination. The State suggests that the parents or guardians of the children in these grades have the examinations done by their family dentist. We have attached the report your dentist is to use for the examinations to this letter.

We appreciate your understanding that we are required by state law to either do our own dental examination OR we may accept proof that a private dental examination was completed within one calendar year prior of your child's entry into the grade in which the examination is required. (Board Policy No. SC1403, 1407 Title 22 Section 12.41)

In order to have your child's records complete, the attached (on back) form H514.027 must be completed by your dentist and **returned to your child's school nurse by October 15TH of this coming school year. If this form is not returned, the school dentist / hygienist will perform the state mandated dental examination of your child.** If you wish for the examination to occur at school, free of cost, please return this letter with your signature and notification to your school nurse. Thank you for your understanding.

Respectfully,

Jeffrey I. Zweiback

Dr. Jeffrey Zweiback,
Director of Educational Services

PARENT FORM

RE: ____
(Student Name)

School: ____________________________ Grade: _______ Room/HR: __________

____ I request that a dental examination be done at my child's school

____ My child has had a private dental examination and the signed H514.027 form is attached as proof

Date: ________________ Parent's Signature: ____

H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL ______________________________ DATE ______________ 19__

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
Last First Middle		☐ M ☐ F		

ADDRESS

No. and Street	City or Post Office	Borough or Township	County	State	Zip

REPORT OF EXAMINATION

		TOOTH CHART																
		RIGHT								LEFT								
UPPER		1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER		32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
	UPPER																	Upper
	LOWER																	Lower

Is The Child Under Treatment Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

____
Date of Dental Examination

____
Signature of Dental/Examiner

____
Print Name of Dental Examiner

____
Address