SPRINGFIELD SCHOOL DISTRICT

Jeffrey J. Zweiback, *CAGS*
Director of Teaching & Learning for Secondary Education

111 West Leamy Avenue
Springfield, PA 19064
610-938-6016

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 1st. If this form is not returned, the school dentist / hygienist will perform the state mandated dental examination of your child.** If your private dentist has completed a private dental examination, please return this form as soon as possible with the attached "Private Dentist Report".

Thank you for your understanding.

Respectfully,

Jeffrey J. Zweiback

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Director of Teaching and Learning for Secondary Schools

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 (08/2011-under review)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

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

NAME OF SCHOOL _____ DATE _____ 20 ___

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

ADDRESS

No. and Street | City or Post Office | Borough/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