



Lincoln Christian School Dental Examination Report

This is to certify that I have thoroughly examined the teeth of:

_____ (Please print full name of patient)

Please Check ONE:

_____ **No dental treatment is necessary at this time.**

_____ **All necessary dental treatment has been completed.**

_____ **Dental treatment is scheduled.**

Further recommendations:

_____ (Date)

_____ (Signature of Dentist)

Please return this form to the office. If you have any questions, please contact the Lincoln Christian School Nurse at 488-8888 x 230.