HOLY ANGELS CATHOLIC
ELEMENTARY SCHOOL
230 North 8th Avenue • West Bend, WI 53095
(262) 338-1148 www.has.pvt.k12.wi.us

DENTAL EXAMINATION

Washington County

Name: _____ Date of Birth: _____

Address: _____

_____

Grade Entering: _____

Date of Examination: _____

A complete Dental Examination of this mouth indicates:

_____ Child is in need of dental care (see comments below)

If dental care is required, have arrangements been made for correction?

____ Yes ____ No

_____ All dental requirements have been fulfilled.

Dentist's Signature: _____

Address: _____

Comments:

*This form should be returned to **Holy Angels School***