

**Bristol Township School District  
Health Services Department**

5 Blue Lake Road  
Levittown, PA 19057

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Dear Parent or Guardian:

In accordance with Pennsylvania School Law, **dental examinations** are required for school children in Bristol Township in the following grades:

1. Upon entry into school—**kindergarten or first grade**
2. In the **third grade**
3. In the **seventh grade**

These grades were chosen because they normally mark important periods of growth and development in a child’s life.

You may choose to have this examination done by your family dentist or have the school dentist examine your child. It is preferable to have your own dentist do it, as he/she is more familiar with your child and their history.

If you choose to have your own dentist perform the examination, please provide written proof. The private dental exam should have been completed no earlier than 12 months before the opening of the current school year.

Thank you for your cooperation in this important health matter. *If you have any questions, please call your school nurse at the number listed below.*

<b>School:</b>	<b>Phone Number/Fax Number</b>
Mill Creek Elementary School	<b>267-599-2454/</b> 267-599-2468
Brookwood Elementary School	<b>267-599-2421/</b> 215-547-5737
Keystone Elementary School	<b>267-599-2490/</b> 215-788-1516
Ben Franklin Middle School	<b>267-599-2312/</b> 267-599-2341
Neil Armstrong Middle School	<b>267-599-2262/</b> 215-949-1721

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

NAME OF SCHOOL \_\_\_\_\_ DATE \_\_\_\_\_ 20 \_\_\_\_

NAME OF STUDENT			<u>AGE</u>	<u>SEX</u>	<u>GRADE</u>	<u>SECTION/ROOM</u>
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	6C	7 D	8 E	9 F	10 G	11 H	12 I	13J	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
EXAM UPPER																	Upper
LOWER																	Lower

Untreated Decay: No Yes

Treated Decay: No Yes

Any Sealants on Permanent Molars: No Yes

Treatment Urgency: None Early Urgent

\_\_\_\_\_  
Date of Dental Examination

\_\_\_\_\_  
Signature of Dental Examiner Print Name of Dental Examiner

\_\_\_\_\_  
Address of Dental Examiner