



BURLINGTON
AREA SCHOOL DISTRICT

HEALTH SERVICES DEPARTMENT

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“Optimal health and wellness is essential for proper development and learning.”

Dental Health

Last Name: _____ **First Name:** _____ **MI:** _____

School: _____ **Grade:** _____ **DOB:** _____

Parent / Guardian: _____

Address: _____

To The Parent / Guardian:

The Burlington Area School District has a health program that is designed to improve, protect and promote the health of each child. As part of this health program we strongly urge you to take your child to the dentist of your choice at least twice a year for a dental examination and whatever treatment may be necessary. When the examination and treatment are completed, this form should be returned to the school.

To The Dentist:

Check one of the following statement before signing this form:

- 1. Teeth were found in satisfactory condition
- 2. All necessary dental work has been completed
- 3. Dental work is necessary and in the process of being completed

Signature of Dentist: _____ **Date:** _____

Address: _____ **Phone:** _____