

**GREAT NECK PUBLIC SCHOOLS**  
**Health Services**  
*Dental Health Report*

Date \_\_\_\_\_

Teacher's Name \_\_\_\_\_

This is to certify that \_\_\_\_\_

\_\_\_\_\_ Is under my care for dental treatment

\_\_\_\_\_ Has completed dental treatment

\_\_\_\_\_  
Signature of Dentist

\_\_\_\_\_  
Address

- This report should be returned to the classroom teacher or school nurse.