GREEN COUNTY HEALTH DEPARTMENT

DENTAL REFERRAL

NAME: ____

SCHOOL: ______________________ DATE: ______________

GRADE: ______________________

TO THE PARENTS

Your child's school has a health program that is designed to improve, protect, and promote the health of each child. As a part of this health program we urge you to take your child to a dentist of your choice, at least once a year for a dental examination and for whatever treatment may be necessary.

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TO THE PARENTS

Please return this sheet to the teacher when checked and signed by you or by the dentist.

☐ A dental appointment has been made for my child.
☐ My child's last visit to the dentist was (date) ______________________.

______________ ______________________________
(Date) (Parent's Signature)

Yes, I recognize that this digital signature takes place of a handwritten signature, pursuant to Wis Stats 137.15, 137.16, & 137.7.

TO THE DENTIST

Please check appropriate statement before signing card.

☐ All necessary dental work has been completed.
☐ Treatment is in progress.
☐ No dental work is necessary.

Remarks:

____

______________ ______________________________
(Date) (Dentist's Signature)

Yes, I recognize that this digital signature takes place of a handwritten signature, pursuant to Wis Stats 137.15, 137.16, & 137.7.