

DENTAL REFERRAL CARD  
Ozaukee County

School \_\_\_\_\_ Grade \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_

**TO THE PARENTS:**

Our 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 strongly urge you to take your child to a dentist of your choice at least once a year for a dental examination and whatever treatment may be necessary. When the examination and treatment are completed, return this card to school.

**TO THE DENTIST:**

- No dental work is necessary.
- All immediate dental work has been completed.

Dentist's Signature \_\_\_\_\_ D.D.S. Date \_\_\_\_\_

If your child HAS been to the dentist for a dental examination and necessary corrections within the past year, please sign.

Parent's Signature \_\_\_\_\_