

DENTAL HEALTH CARD

Name of Student _____

Birth Date _____ Grade _____

- No Treatment Necessary
- Needs Treatment
- Treatment Completed
- Under Treatment
- Refused Treatment

Check One

Date _____ D.D.S. _____

MAIL OR RETURN CARD TO SCHOOL WHEN SIGNED BY YOUR DENTIST

MCPS Form 525-17 Rev. 8/97