SC Youth ChalleNGe Academy

Statement of Dental Health

Student Name: ____

Examination Date: ___________________

____I certify that I have examined this student and he/she has no apparent dental problems or concerns at this time.

____I certify that I have examined this student and he/she does have some dental problems or concerns at this time. (See below):

Indicate Dental Treatment Plan and Time Period Below, if applicable:

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Indicate Orthodontic Treatment Plan Below, if applicable:

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Note: Students will not be allowed to keep routine orthodontic appointments, during the first eight (8) weeks.

Wisdom teeth will not be removed during the twenty-two weeks cycle. If surgery is indicated, it needs to be completed at least two weeks prior to the scheduled registration date of July 10, 2017. Student must be completely healed and a release from the dentist with paperwork showing discharge.

_______________________________   ________________________________

Dentist's Printed/Typed Name   **Address**

_______________________________   (_______)_________________________

Dentist's Signature   **Telephone**