DENTAL REFERRAL FORM

KENOSHA COUNTY SCHOOLS
to be sent to the school

SCHOOL _____ DATE _____

NAME _____ AGE _____ GRADE _____

ADDRESS _____ TOWNSHIP/VILLAGE _____

To the Parents or Guardian:

Teeth are important to your child's health, comfort, behavior, progress in school and personal appearance. In the best interest of your child's health, we suggest that you take your child to your family dentist for an examination and the dental care that is necessary.

To the Dentist:

Check one of the following statements before signing and returning this form:

_____ I have examined the teeth of the above child. No dental work is necessary.

_____ Some dental work has been completed.

The following dental work needs to be completed: _____

_____

_____

_____

DATE _____ SIGNATURE OF DENTIST _____

SUPPLIED BY: Kenosha County Division of Health
8600 Sheridan Road, Suite 600
Kenosha, WI 53143
605-6700