



ST. PETER SCHOOL
206 E. Washington St.
Slinger, WI 53086
262-644-8083 X24 or X25
Fax 262-644-7951

NAME _____

GRADE _____ **AGE** _____ **DATE** _____

ADDRESS _____

A complete Dental Examination of this mouth indicates:

_____ **Child is in need of dental care. OR**
_____ **All dental requirements have been fulfilled.**

**If dental care is required, have arrangements been made
for correction?**

_____ **YES** _____ **NO**

Dentist's Signature _____ **D.D.S.**

Comments _____

Please return form to: St. Peter School
206 E. Washington St.
Slinger, WI 53086