Sagaponack Common School
P.O. Box 1500
Sagaponack, NY 11962

DENTAL HEALTH CERTIFICATE

Name:_ ____________________ Date:___________________

This is to certify that I have examined and hereby inform you that:

_____ No treatment is necessary

_____Treatment in progress

_____Treatment is complete

___________________________ ___________________________
Dentist's Name Dentist's Signature

Please return this form to your child's school nurse.