SCHOOL DISTRICT OF HOLMEN

502 North Main Street, P.O. Box 580
Holmen, Wisconsin 54636
(608) 526-6610
www.holmen.k12.wi.us

DENTAL REFERRAL CARD

STUDENT'S NAME_____GRADE: _____

PARENT(S)/GUARDIAN(S): _____

ADDRESS/CITY/STATE/ZIP: _____

PHONE NUMBER: _____DATE OF BIRTH: _____

SCHOOL YEAR: _____ SCHOOL ATTENDING: _____

TO THE PARENT(S)/GUARDIAN(S):

Our school has a health program that is designed to improve, protect, and promote the health of each child. As a part of this health program, we strongly urge you to take your child to a dentist of your choice at least once a year for a dental examination and whatever treatment may be necessary. When the examination and treatment are completed, please return this card to the office of the school your child will attend.

TO THE DENTIST:

Check one of the following statements before signing this card -

( ) No dental work is necessary.

( ) All immediate dental work has been completed.

DATE: _____ _____
Signature of Dentist

*****Do not return card to school unless card is signed by dentist.***