York College of Pennsylvania
Department of Nursing
Dental Examination Report for Nursing Students

Please return this report to the Department of Nursing Office

Phone (717)815-1243 Fax (717)849-1651

Student Name: _____

Permanent Address: _____
(number) (street)
_____
(city) (state) (zip code)

This is to certify that the above named came to me on _____ for an
(date)
examination of her/his teeth which I found to be in _____ condition.

I have since given the necessary treatment.

How often are teeth examined? _____

Care of mouth: Good _____ Average _____ Poor _____

Teeth: Good _____ Average _____ Poor _____

Occlusion: Good _____ Average _____ Poor _____

Condition of Gums: _____

Remarks:
_____
_____
_____
_____

Date: _____ Signature: _____

Printed Name or Stamp: _____

Address: _____

_____