St. Catherine
Early Childhood Education Center
Dental Form

1. Student Information

Student Name_____

Address_____ Birthdate_____

Parent/Guardian's Name(s)_____

2. Dental Treatment (Mark for treatment actually done)

__ Dental Prophylaxis (cleanings)

__ Restorations

__ Extractions

__Other_____

3. Dentist Information

In the event of a dental emergency, please contact the following dentist:

Dentist Name_____

Address_____

City_____ State_____ Zip Code_____

Phone Number_____