



St. Catherine
Early Childhood Education Center
Dental Form
2024-2025



1. Student Information

Student Name _____
Address _____ Birthdate _____
Parent/Guardian's Name(s) _____

2. Dental Treatment (Mark for treatment actually done)

<input type="checkbox"/> Dental Prophylaxis (cleanings)
<input type="checkbox"/> Restorations
<input type="checkbox"/> Extractions
<input type="checkbox"/> 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 _____			

