To: Family Dentist/Parents

From: Swampscott Elementary School Nurses

Re: Proof of Dental Care

CERTIFICATION OF DENTAL CARE

The Swampscott Public School System requires that proof of appropriate dental care has been provided to each child entering kindergarten.

Name of Child:_____
(last) (first) (middle)

Date of Birth: _____

To be completed by dentist:

I certify that this child has been seen for routine or other dental care.

Dentist's signature _____

Address _____

Telephone _____

Date _____