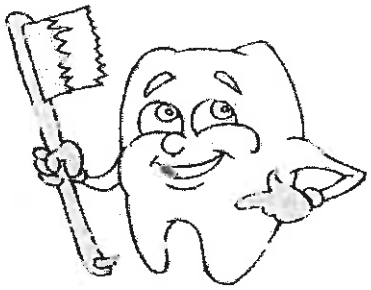
Shenandoah Valley Academy
Dental Examination Record
Must by completed by all students.



The following information is to be completed by a dentist. Please return this form directly to Shenandoah Valley Academy Health Services, 234 West Lee Highway New Market, VA 22844. *Student should have all necessary work done prior to admission to Shenandoah Valley Academy.*

Student's name (print of type) _____ Social Security # _____ Date of Birth _____ Grade _____

Home Address: _____ Phone: _(___)_____

Date of Last Examination: _____ Requires Treatment: ☐Yes ☐No

Additional Remarks: _____

Wearing Braces? ☐Yes ☐No If yes, plan of treatment? _____

Orthodontist's Name: _____ Telephone: _____

Dentist's Signature: _____ Print Name: _____

Dentist's Address: _____

I hereby certify that this student is in good dental health.

_____ _____

Signature of Dentist Date