



ALLEGANY-LIMESTONE CENTRAL SCHOOL

3131 Five Mile Road • Allegany, NY 14706

District Office

Phone: 716-375-6600

Fax: 716-375-6629

Middle-High School

Ext. 2110/2100

Fax: 716-375-6630

Elementary School

Ext. 4172

Fax: 716-375-6628

Special Education

Ext. 4164

Fax: 716-375-6601

Bus Garage

Ext. 6612

Fax: 716-375-6627

Dental Health Certificate			
Parent/Guardian: New York State law {Chapter 281} permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.			
Section 1. To be completed by Parent or Guardian (Please Print)			
Child's Name:		Last	First
		Middle	
Birth Date:	/ /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Month Day Year		
School: Name		Grade	
Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.			
I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.			
Parent Signature _____		Date _____	
Section 2. To be completed by the Dentist			
I, The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:			
<input type="checkbox"/> Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.			
<input type="checkbox"/> No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.			
Note: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school			
Dentist's name and address (please print or stamp)		Dentist's Signature	