DEPT. OF HEALTH &
HUMAN SERVICES

MONTGOMERY COUNTY
PUBLIC SCHOOLS

DENTAL HEALTH CARD

Name of Student ______________________________

Birth Date ____________________ Grade ____________________

Check One

- ❍ No Treatment Necessary ❑
- ❍ Needs Treatment ❑
- ❍ Treatment Completed ❑
- ❍ Under Treatment ❑
- ❍ Refused Treatment ❑

Date ______________ D.D.S. ______________________________

MAIL OR RETURN CARD TO SCHOOL WHEN SIGNED BY YOUR DENTIST

MCPS Form 525-17 Rev. 8/97

PLACE
STAMP
HERE

______________________________ SCHOOL

MARYLAND