Please return TOP Portion to School TOMORROW

Hazleton Area School District

School: _____ Grade:_____ Section:_____

Name of Student: _____

(The School Health Act requires that all students in grades K,3,and 7 receive dental screenings during the school year.)

Please select **one** of the following:

_____ I want my child screened by the HASD Dental Provider.

_____ I want my child screened by my Private Dentist: *** Dentist's name**:_____

Date of last visit (month and year)_____

_____ _____

Parent/Guardian Signature Parent/Guardian Address

_____

Parent/Guardian Phone Number

(Detach this portion ***only if Private dentist*** was selected)

Have form completed by family dentist at 6 month check-up and return to school

This is to certify that:

Student name: _____ School:_____ Grade:_____

_____ is receiving dental treatment.

_____ has completed dental treatment.

Date of last Prophy/ Fluoride Tx:_____

Dentist Signature:_____ Date:_____

It is the policy of the Hazleton Area School District not to discriminate on the basis of race, sex, color, national origin or handicap in its educational programs, activities, or employment policies as required by the Title IX of the Education Amendments of the 1972 and Section 504 of the Rehabilitation Act of 1973, the Age Discrimination in Employment Act of 1967, and the Americans with Disabilities Act of 1990. Inquiries regarding compliance may be directed to: **Daniel Rodgers, Title IX Coordinator, 570. 459.3111 x 3444**