



**Calvary Early Learning Center**  
**Murrysville, PA**  
**FAMILY DENTIST REPORT**

**(Pennsylvania requires a Family Dentist Report upon entrance to Kindergarten)**

**Parents Complete This Section:**

Name of Child    Last    First    Middle	School  <b>Calvary Early Learning Center</b>	Due Date  <b>October 15, 2026</b>
Home Address	Zip Code	Home Phone Number

**Dentist will complete this Section:**

The above named child last visited my office on \_\_\_\_\_ (give date).

At that time all necessary dental corrections had been made. Yes ☐    No ☐

If the answer above is "No" fill in the following:

This child is in need of treatment for one or more of the following:

Primary teeth \_\_\_\_\_ Fillings ☐    Extractions ☐

Permanent teeth \_\_\_\_\_ Fillings ☐    Extractions ☐

Diseases of the Supporting Tissues \_\_\_\_\_ ☐

Gross malocclusion which is producing a facial deformity or is interfering with function ☐

Cleft palate and/or cleft lip ☐    Other congenital malformations ☐

Prosthetic replacements for lost or missing teeth \_\_\_\_\_ ☐

This child is currently under treatment \_\_\_\_\_ Yes ☐    No ☐

Signature \_\_\_\_\_ **D.D.S.**

Date Submitted \_\_\_\_\_ Address \_\_\_\_\_