Year:        Month:      Day:

Dear Parents,

○○ School, ○○ City ＿＿＿＿＿＿＿＿

**Notice of Medical Examination for Absentees on the Day of Dental Examination**

(歯科)

Since your child was absent on the day of the dental examination held on (\_\_\_\_/\_\_\_\_\_ m/d) \_\_\_\_\_day, he/she could not receive the dental examination for this year. If you wish to have a check-up for absentees, Dr. \_\_\_\_\_\_, a dentist of school, will kindly allow you to have a check-up at \_\_\_\_\_\_\_\_\_ dental clinic. For absentee check-up’s, please indicate your preference by circling one of the items below "Cut Line".

**Submission deadline： m:    /d:    (      　 day）**

|  |
| --- |
| ＿＿＿＿＿　dental clinic Dentist of school）  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, ○○ city |

１ Please take your child with you. Please tell the receptionist about the examination for absentees.

The examination fee for absentees will be free of charge.

２ If your child needs treatment after the absentee check-up and he/she wants to continue to see a dentist at \_\_\_\_\_\_\_\_\_\_ dental clinic, you will be charged extra for the medical expenses. Please bring your health insurance card and recipient's certificate of medical and welfare expenses (MARUFUKU).

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| 【 Contact Information 】  Health teacher at ○○ School ＿＿＿＿＿＿＿＿＿＿  ＴＥＬ\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

―――――――――――――――――――――――　Cut　Line　――――――――――――――――――――

**Medical Examination Request Questionnaire for Absentees of Dental Examination**

**(歯科検診)**

Grade＿＿ Class\_＿＿ Student’s name＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

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We will contact you again when the date is officially decided.