



# Dental Services Application

## Contact Information

Pre/Elementary School \_\_\_\_\_

Principal Name \_\_\_\_\_

Address (mailing) \_\_\_\_\_

School Phone # \_\_\_\_\_

Address (physical) \_\_\_\_\_

Principal Email \_\_\_\_\_

City/Zip \_\_\_\_\_

Person Completing This Form: \_\_\_\_\_

School Nurse Name \_\_\_\_\_

School Nurse Email \_\_\_\_\_

School Nurse Phone \_\_\_\_\_

Fax # \_\_\_\_\_

School Contact/Coordinator: \_\_\_\_\_ Phone # \_\_\_\_\_ Email: \_\_\_\_\_

## School Enrollment

Preschool - # of children enrolled \_\_\_\_ am \_\_\_\_ pm

Classroom Hours - \_\_\_\_\_ am - \_\_\_\_\_ pm

Kindergarten- # of children enrolled \_\_\_\_ am \_\_\_\_ pm

Classroom Hours - \_\_\_\_\_ am - \_\_\_\_\_ pm

## General Information

Is your school on a modified calendar? \_\_\_\_ Yes \_\_\_\_ No (If yes, please attach school schedule)

What percentage of the children enrolled do you estimate will participate in the program? \_\_\_\_\_ %

## Support

Do you have a room available for 3 days that can be used to provide dental services to the children? \_\_\_\_ Yes \_\_\_\_ No

Do you have a volunteer or staff person available to assist with escorting children to and from class? \_\_\_\_ Yes \_\_\_\_ No

## Completed Application

Please return this form via fax, email or US mail by **April 1, 2017** to:

Kern County Children's Dental Health Network, ATTN: Diana Baltazar (dibaltazar@kern.org)

1800 30th St., #230, Bakersfield, CA 93301

Phone (661) 377-0325 Fax (661) 377-0329