



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: _____

Projected Enrollment in The 2018-2019 School Year

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)

Will your school be receiving dental services from any other agencies? ____ Yes ____ No

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 23, 2018** 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