



A partnership program between the Kern County Superintendent of Schools and West Kern Community College District

Dental Services Application

Contact Information

Pre/Elementary School _____

Principal 's Name _____

Address _____

School Phone # _____

City/Zip _____

Principal Email _____

School Nurse Name _____

School Nurse Email _____

School Nurse Phone _____

Other Contact Name _____

School Enrollment

Preschool - # of children enrolled ____ am ____ pm

Classroom Hours - _____ am - _____ pm

Elementary - # 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

Do you have a community collaborative ie. Healthy Start within close proximity of your school? If yes, please name:

Completed Application

Please return this form by fax, email or US mail by **March 25, 2011** to:

Kern County Children's Dental Health Network, ATTN: Paula Salcido (pasalcido@kern.org)

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

Phone (661) 377-0322 Fax (661) 377-0329