Dental Prevention Program

2019-2020 School Participation Form and Agreement

By returning this form you are stating that your school is interested in participating in the dental prevention program and that you will abide by the contents of this and the accompanying document.

Date:

School Name: ________________________________________________________________________

Address: ____________________________________________________________________________

City: ___________________________________  State: ________  Zip: __________________________

County: ____________________ Principal’s Name: __________________________________________

Contact Person: ___________________________ Email: ______________________________________

Job Title: ________________________________ Phone Number: _______________________________

Number of students:  Pre K _____  K____ 1st____ 2nd____ 3rd____ 4th____ 5th_____ 6th____

_____ Number of total students at the school.  _____ The grades that are presently enrolled in your school.

_____ Current Free and Reduced Lunch Percentage.

_____ Earliest time of day the dental program can begin.

Are other dental mobile programs scheduling for your school? ______ If yes, when? _______________

Please be aware we may not be able to service your school if outside groups are planned. Please call me to discuss further.

Your signature signifies that your school will do the following promotional activities in order to reach and educate the parents about the oral health program available:

- Announcement of dental program on your website, facebook, twitter
- Include the dates on the school calendar for parents to see
- Class/Grade/School Newsletters
- Distribution of reminders that the NKHD will provide both to parents and within the school

School contact’s signature here is an agreement to abide by the contents of the accompanying Agreement, including promotion of the program and decay follow-ups. This form is also an agreement by the NKHD to abide by the same contents:

____________________________________________________________________________________

Please return this form by mail, email or fax to:

Linda.Poynter , RDH, BHS
linda.poynter@nkyhealth.org
Phone: 859.363.2035  Fax: 859.578.3689

Northern Kentucky Health Department
8001 Veterans Memorial Drive, Florence KY 41042  |  859-341-4264  |  www.nkyhealth.org