

**BEST Dental Help Roster**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Please circle the program option:**  Head Start ECEAP EHS Childcare | | | | | |
| **Site Name:** | | | **Classroom Phone Number:** | | |
| **Family Advocate:**  **Family Advocate Phone Number:** | | | **Class Start and end time:** | | |
| **Child Last Name** | **Child First Name** | **DOB** | | **Provider One**  **Number** | **Dental Home Name**  \*if none, write none |
| *Example*  *Smith* | *Sarah* | *1/2/2018* | | *38572048467* | *Kitsap Kids Dentistry* |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |
|  |  |  | |  |  |

*\*\*Classes with an AM and PM option must be completed on two separate forms. Highlight children that have declined services.*