

**BEST Dental Help Roster**

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