ANNUAL SCHOOL FLUORIDE MOUTH RINSE PROGRAM REPORT

Please put your address below:

CROSS OUT INCORRECT INFORMATION AND MAKE CORRECTIONS ON LINES BELOW


PLEASE COMPLETE AND RETURN BY:

Without this form, we cannot order your fluoride supplies for the upcoming school year.

1. Principal: __________________________ Telephone: __________________________
2. Coordinator: __________________________ Telephone: __________________________
   Coordinator e-mail address: __________________________
3. Circle the grades that participate in the Fluoride Mouth Rinse Program and on the lines below, enter the total number of students in each circled grade. PLEASE INCLUDE ALL STUDENTS – PARTICIPATING OR NOT.

   K  1  2  3  4  5  6  7  8
   ___ ___ ___ ___ ___ ___ ___ ___
   Total number: ____________
4. For each participating grade, enter the number of students PARTICIPATING in the Fluoride Mouth Rinse Program.

   K  1  2  3  4  5  6  7  8
   Total number participating: ____________
5. Will your school be participating in the fluoride mouth rinse program next year?  □ NO  □ YES
6. Will additional students participate next year? □ NO  □ YES If yes, how many? __________
7. When did your students begin rinsing for the current school year? Month: ___________ Day: _______
8. When did/will your students stop the rinse program?  Month: ___________ Day: _______
9. What day(s) of the week do your students rinse? □ Monday  □ Tuesday  □ Wednesday  □ Thursday  □ Friday
10. How many full kits will remain when the program finishes in June? Full Kits Remaining: ____________

A FULL KIT CONTAINS:
1 box of 20 3-gram packets of fluoride,
24 packages of cups,
8 packages of napkins,
200 trash bags, 1 container and 1 pump

11. What is the expiration date on the fluoride packets that remain?  Month ___________ Year_________
12. What flavor would you like for next year?  Please select ONE.
   □ Bubblegum  □ Grape  □ Mint  □ Orange  □ Very Berry

Please note: If the school decides to discontinue participation in the rinse program, the school shall assume responsibility for the shipping costs associated with kit return.
13. Will the FMR Coordinator remain in this position next year? □ Yes □ No
   If not, who will be the replacement? __________________________________________________________

14. Does your school provide oral health education? □ Yes □ No
   If yes, in what grade levels? Please circle. K 1 2 3 4 5 6 7 8
   Please describe.
   __________________________________________________________________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________

15. Would you be interested in an educational program on any of the following topics? Check all that apply.
   □ Not at this time □ Fluoride (for teachers/nurses) □ Oral Health (for students) □ Tobacco (for students)

16. Does your school provide dental screenings? □ Yes □ No
   If yes, what grade levels? Please circle. K 1 2 3 4 5 6 7 8

17. Does your school provide referrals? □ Yes □ No

18. Does your school provide follow-up? □ Yes □ No

Comments: ________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

Your local health officer will be informed in the school’s participation in the “Save Our Smiles” fluoride rinse program.