**Return to:** Deborah Tracy, RDH, MAS
Regional Oral Health Coordinator
Southern Jersey Family Medical Centers, Inc.
860 S. White Horse Pike (Rt. 30)
Hammonton, NJ 08037
Telephone: (856) 935-6203
Fax: (856) 935-6233

(To be completed by Department of Health)
Date: ______________________________

Ship ______kits   Unit dose _____
Flavor: ☐ B ☐ G ☐ M ☐ O ☐VB
Participation Percentage: _________
County: ____________

# 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.

| ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | Total number participating: ______ |
|---|---|---|---|---|---|---|---|---|---|
| K | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |

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.**

Continued on back page ➔

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.