All-Star Smiles Data Collection Form
Education, Screening & Preventive Treatment

It is critical that after the event, you please complete and email this form to Ericka@allstarsmiles.org so we can track our impact. Thank you!

Event Information

Event Name: ____ City: ___________________________

State: ______________________ Event Contact Person: ____

Email Address: ____

Children Information

Number of children: Infant/Toddler (ages under 3) __________

Preschool through first grade (ages 3-6) ________ Grades 2nd and 3rd (ages 7-9) __________

Grades 4th through 6th (ages 10-12) ____________ Grades 7th and 8th (ages 12-14) _________

Grades 9th through 12th (ages 15-18) ___________

Gender of children: Female ________ Male __________ Gender Unknown ___________

Race/Ethnicity of children: White _________ Black ________ American Indian _______ Asian ______

Islander _______ Hispanic Latino ______ Other_______ Unknown _______

Total number of children: _______

Services Rendered

Please indicate the total number of children who received each service. If no children received a particular service, enter 0.

Oral hygiene instructions _______ Oral evaluation ________ Fluoride treatment ________
Sealant (per tooth) ________ Interim caries arresting medicament application–per tooth ______

Number of Volunteers

Dentist: _________ Dental Hygienists: __________ Dental Assistant: _______ Dental Student: _________

Dental Hygiene Student: __________ School Nurse: __________ Other: __________