School Sealant Program
Permission Slip

Your child's school has been chosen to participate in the DENTAL3 School Sealant Program. Dental sealants are plastic coatings put on the back teeth to seal out germs and prevent cavities. The screening and sealants are **free** and are done by dental professionals.

Name of Child: _____
(Last) (First) (Middle Initial)

Teacher: _____ Grade:_____

☐ **YES,** I want my child to have a dental screening and dental sealants.

***Even though your child may have received sealants last year, please mark yes so we can check them.**

☐ **NO,** I don't want my child to have a dental screening or get dental sealants.

If yes, please complete and sign below

Family Information	Parent/Guardian:	Child's date of birth: ____/____/____ Mo / Day / Year
	Mailing address:	Text message for follow-up? ☐ Yes ☐ No
	Daytime phone number:	Mobile phone number:
	Email address:	
	My child is taking (list medications):	
	My child is allergic to:	
	My child has: ☐ Asthma ☐ Behavioral considerations (please describe):	

Insurance	Health Insurance (check one) ☐ Oregon Health Plan (OHP) / Medicaid ID# _____ ☐ Private Dental Insurance Company _____ ☐ No health insurance	These services are provided at **no cost** to you.

Please Read

If you said YES to screening and sealants, your signature below indicates:
As the legal parent/guardian, I hereby consent to the release and exchange of information, including any personal health information, between the dental sealant staff, school staff, insurance carriers, the child's dentist, applicable Coordinated Care Organization, and/or the Dental Care Organization of record. I have received a copy of "Notices of Privacy Practices."
I also understand a dental student closely supervised by a licensed dental professional may provide treatment.

Parent/Guardian Signature:/s/_____ Date: _____

This digital signature complies with the UNIFORM ELECTRONIC TRANSACTIONS ACT (1999).

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The confidentiality of your protected health information, also called your medical record, is a high priority at Dental 3. There are a number of reasons we may need to use this information or disclose it to others. This Notice of Privacy Practices is provided to inform you of the ways we can use and release information from your medical record. THIS PAGE IS NOT THE FULL NOTICE OF PRIVACY PRACTICES. The full notice is available upon request. In addition to our longstanding commitment to protecting your information, there are certain obligations we have under federal law. One of those obligations is to provide you with this Notice.

THINGS EXPLAINED IN THE FULL NOTICE OF PRIVACY PRACTICES

- **How we may use and share your health information without your permission to:**
  - Provide treatment to you
  - Get paid for the services we provide to you
  - Make reports to federal, state, and local agencies and others when the law requires such reporting
  - Make reports or share information for public health, safety, and/or research purposes.

- **How we can share your information without your permission, but only if we give you a chance to object:**
  - To share information about you to family, friends, or others involved in your care for payment for the services you receive
  - To share information in case of a disaster to let your family and friends know where you are and your general condition

- **How we can use and share your medical information only with your permission for disclosures other than those described above.**

- **Your legal rights under federal privacy laws include your right to:**
  - Ask to see and copy your medical information
  - Ask that incorrect or incomplete information in your medical information be corrected
  - Ask for a list of the places we have sent your information unless it was sent with your permission, for payment, treatment, or health care operations
  - Ask that we limit the information we use or share for treatment, payment, or healthcare operations, or the information we share with family members or others involved in your care. We are not required to agree to your request
  - Ask that we communicate with you in a confidential manner
  - Ask for a paper copy of the Notice of Privacy Practices at any time
  - Be notified in the event of a breach of unsecured, protected health information
  - File a complaint if you think your privacy rights have been violated
  - Pay out of pocket in full for a healthcare item or service and restrict disclosure of that particular item or service to your health plan provider