



*Healthy Mouth = Healthy Child*

## DENTAL SEALANTS AND SCREENINGS

**Please return a signed permission slip to use this service.**

No cost to you (insurance billed) sealants and dental screenings are offered at your child's school. A dental screening is a quick look inside your child's mouth to check the overall health of their teeth.

- ☺ Healthy teeth are important to your overall health
- ☺ When dental sealants are done in school, you miss less work and your child misses less school
- ☺ Dental sealants are done by dental care professionals
- ☺ See your dentist at least once a year



For more  
information,  
please call us at  
503-842-2356.

Before

After



### The Problem: Cavities

- Cavities are the most common chronic childhood disease
- About 1 of 5 (20%) children aged 5 to 11 years have at least one cavity

### The Solution: Dental Sealants

- Dental sealants are protective coatings put on the back teeth
- Sealants are a quick and easy way to prevent cavities

# School Sealant Program Permission Slip



No cost to you (insurance billed) dental screenings and sealant services are now offered at your child's school. Dental sealants are protective coatings put on the back teeth and are a quick and easy way to prevent cavities. The screening and sealants are done by dental care professionals.

Name of Child: _____		
(Last)	(First)	(Preferred Name)
Child's Date of Birth (mm/dd/yy): ____ / ____ / ____ Teacher: _____ Grade: ____		
School: _____		

### Dental Screening: a quick look inside the mouth to check the overall health of teeth

YES                       NO

**Sealants: applied to teeth to prevent cavities**

**If yes, please complete and sign below**

YES                       NO

Contact Information	
Parent/Guardian:	
Best phone number to reach you:	Permission to Text: <input type="checkbox"/> Yes <input type="checkbox"/> No
Email address:	
Mailing address:	

### Please provide the following information so we can better serve your child:

My child is taking (list medications):	None: <input type="checkbox"/>
My child is allergic to:	None: <input type="checkbox"/>
Any current medical problems:	None: <input type="checkbox"/>
Any behavioral considerations:	None: <input type="checkbox"/>
Other information to help us better serve your child:	None: <input type="checkbox"/>

### Please complete the section below.

Health Insurance: <input type="checkbox"/> Oregon Health Plan (OHP) / Medicaid ID# _____ <input type="checkbox"/> Private dental insurance company _____ <input type="checkbox"/> No health insurance	<p><b>These services are no cost to you!*</b></p> <p><small>*insurance will be billed</small></p>
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By signing below you:

As the legal parent/guardian, I hereby consent to the release and exchange of information, including any relevant 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." Privacy Practices are available on Tillamook Community Health Center website <https://tillamookchc.org/patient-forms/>

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Collecting demographics helps us better serve our community.

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First)

**Ethnicity (optional)**

- Hispanic
- Non-Hispanic

**Race (optional) Please check all that apply**

- Alaskan Native
- American Indian
- Asian
- Black
- Native Hawaiian
- Pacific Islander
- White
- Other

**Language (optional)**

- \_\_\_\_\_



## SUMMARY OF NOTICE OF PRIVACY PRACTICES

The confidentiality of your protected health information, also called your medical record, is a high priority at Tillamook County Community Health Center. 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 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