RECRUITMENT LETTER and INFORMED CONSENT

UPDATED 2-15-18

NYC
Department of Education Logo

PUBLIC SCHOOL #
Address
Principal
Assistant Principal

[Date]

Dear Parent/Guardian of [Insert Name]:

I am happy to announce that we are 1 of 60 New York City schools to be starting a new, free, dental cavity prevention program. This program will provide care two (2) times each school year to prevent dental cavities.

If you want your child to participate please fill out and sign and return the form below. Participation is free and voluntary. No health insurance is required. However, if your child has Medicaid or other dental insurance, the insurance company will be billed for treatment. You can participate or withdraw at any time.

Prevention in schools is identical to prevention that is given in a dental office, however not all dentists provide preventive care. The U.S. Centers for Disease Control and Prevention recommends school prevention to control and prevent cavities, prevent toothaches, and lower school absence. To get preventive care in a dental office you will have to leave work or home, and your child will have to leave school. Therefore, we are offering preventive care in our school. The program will provide the following care to your child as long as s/he remains in our school.

1. An oral exam to check the teeth, gums, and mouth
2. Tooth cleaning with a tooth brush to remove plaque. A dental hygienist will do this tooth cleaning.
3. Cavity prevention, either:
    a. Fluoride varnish on all teeth, sealants and temporary fillings to prevent and control cavities, or
    b. Fluoride varnish on all teeth and silver diamine fluoride placed on the back teeth to prevent and control cavities.
4. Health education to teach children how to brush
5. A toothbrush and toothpaste
6. A report to the school nurse, and to you, on your child's care
7. Referral to a dentist for further care (if needed), and assist you in finding a local dentist (if needed)
8. Follow your child over time (up to five years) to check that his/her oral health is improving

We are able to do this thanks to a collaboration between our school, the NYU College of Dentistry, and research funds from the Patient Centered Outcomes Research Institute. If you and your child agree to participate, s/he will receive the preventive care assigned to our school (Either 3a or 3b). Both 3a and 3b are expected to have the same level of effectiveness. The research funds allow us to compare these two programs. The information from your child's dental exams will be analyzed to make sure your child's health is improving. Your will not be identified in any analysis. The analysis of the program is research. The care provided to your child is not research, but to compare two standard approaches to prevention.

There are no known health risks to cavity prevention. Cavities appear brown, and silver diamine fluoride will make the color darker. This color change means the cavity has stopped growing.

If you have any questions about the research project you may contact the doctor in charge of the study: Dr. Richard Niederman, Department of Epidemiology & Health Promotion, New York University College of Dentistry, 433 First Ave, Rm 720, New York, NY. Email: rniederman@nyu.edu. Phone: 212-998-9719.

Best wishes,

_____
[Insert Name], Principal

I give my consent for my child to take part in this program and agree to allow his/her health information to be used and shared as described above.

O YES, I agree for my child to participate in this cavity prevention program

O NO, I do not agree for my child to participate in this program

Name of Parent (Print)	Signature of Parent	Date

FAQ: Silver Diamine Fluoride

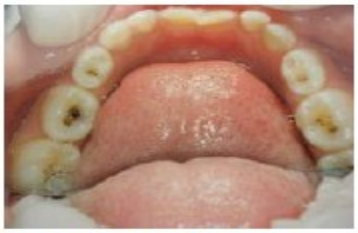
What is SDF? Silver diamine fluoride is an antibiotic liquid. It contains silver and fluoride to both stop and prevent cavities.

Does SDF eliminate the need for fillings? No. SDF stops cavities from growing further. If your child has cavities, they still need fillings.

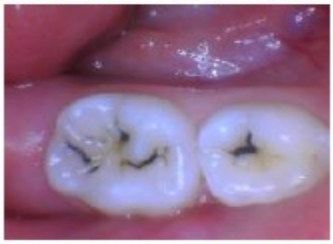
What is the benefit of SDF? SDF stops cavities from growing further, prevents cavities in other non-treated teeth, and eliminates sensitivity. Because SDF stops the cavity from growing, it gives you more time to find a dentists and get fillings.

What are the risks of NOT HAVING SDF? Without treatment the cavity will get bigger, and can turn into a painful toothache or abscess.

What are the risks of HAVING SDF? SDF will turn brown cavities dark brown or black (that is how we know that it is working).



Pit and Fissure Caries



Pit and Fissures w/ SDF

Photos Courtesy Steve Duffin

NYC Department of Education Oral Health Clinic Program
School Parental Consent Form

School Name _____

_____

_____

Office Use Only **Student ID:**

STUDENT INFORMATION

Student's Last Name:

Student's First Name:

Date of Birth: / /

Student's Social Security Number: - -

Sex: O Male O Female **Grade:** **Ethnicity:** O Hispanic O Black O White O American Indian O Asian/Pacific Islander O Other _____

Student Address:

City *State* *Zip Code*

Does your child have any medical history that may complicate dental treatment? O No O Yes (explain below)

_____

PARENT/GUARDIAN INFORMATION

Mother
Last Name:

First Name:

Father
Last Name:

First Name:

Legal Guardian, If Applicable
Last Name:

First Name:

Relationship of legal guardian to student O Grandparent O Aunt or Uncle O Other: _____

Contact Information for parent or guardian

Home Tel: ( ) -

Work Tel: ( ) - Cell: ( ) -

Email: _____

Additional Emergency Contact

Name:

Relationship to Student:

Home Tel: ( ) - Work Tel: ( ) -

Cell: ( ) -

Email: _____

INSURANCE INFORMATION

Does your child have Medicaid? O No O Yes: Medicaid #

Does your child have Child Health Plus? O No O Yes: CHP #

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INSURANCE INFORMATION

Which Plan? ○ Affinity ● Fidelis ● Healthfirst ● Health Plus Amerigroup ● HIP ● MetroPlus ● United Healthcare ● Other

Does your child have coverage through your employer or any other type of insurance? ● No ● Yes, Health Plan: [redacted]

Member ID/Policy Number [redacted]

If your child does not have health insurance, would you like an In-Person Assistor authorized by the NY State of Health Marketplace to contact you to enroll into health insurance? ● No ● Yes

Health Insurance Phone: ([redacted]) [redacted] - [redacted]

What time is best to contact you? _____

PARENTAL CONSENT FOR SCHOOL-BASED ORAL HEALTH CLINIC SERVICES

I have read and understand the services listed on the next page (School-Based Oral Health Clinic Services) and my signature provides consent for my child to receive services provided by the *New York University School-Based Cavity Prevention Program*.
NOTE: By law, parental consent is not required for students who are 18 years or older or for students who are parents or legally emancipated. My signature indicates I have received a copy of the Notice of Privacy Practices.

_____ [redacted] / [redacted] / [redacted]

Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

HIPPA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release oral health information as specified.

[redacted] [redacted] / [redacted] / [redacted]

Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

SCHOOL-BASED ORAL HEALTH CLINIC SERVICES

I consent for my child to receive oral health care services provided by the State-licensed health professionals of the *New York University School based Cavity Prevention Program* as part of the school oral health program approved by the New York State Department of Health. I understand that confidentiality between the student and the oral health clinic provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and oral care decisions. School-Based Oral Health Clinic Services may include, but are not limited to preventative oral health services, restorative oral health services, and emergency procedures that range from comprehensive dental exams, dental hygiene treatments, fluoride treatments, sealants, fillings, and extractions.

NEW YORK CITY DEPARTMENT OF EDUCATION'S
FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF ORAL HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF ORAL HEALTH INFORMATION

My signature on the reverse side of this form authorizes release of oral health information**.** This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing oral health information to be given to the Board of Education of the City of New York (a/k/a New York City Department of Education), either because it is required by law or by Chancellor's regulation, or because it is necessary to pro-tect the health and safety of the student. Upon my request, the facility or person disclosing this oral health information must provide me with a copy of this form. Parents are required by law to provide certain information to the school, like proof of immunization. Failure to provide this information may result in the student being excluded from school.

My questions about this form have been answered. I understand that I do not have to allow release of my child's oral health information, and that I can change my mind at any time and revoke my authorization by writing to the School-Based Oral Health Clinic. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

I authorize the *New York University School-Based Cavity Prevention Program* to release specific oral health information of the student named on the reverse page to the Board of Education of the City of New York (a/k/a New York City Department of Education).

I consent to the release from the School-Based Oral Health Clinic to the NYC Department of Education and from the NYC Department of Education to the School-Based Oral Health Clinic, of oral health information outlined below in order to meet regulatory requirements and ensure that the school has information needed to protect my child's health and safety. I understand that this information will remain confidential in accordance with Federal and State law and Chancellor's Regulations on confidentiality:

Information to Protect Health and Safety:
- Conditions which may require emergency
- Conditions which limit a student's daily activity (Form 103S)
- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law).
- Health insurance coverage

My signature on page 2 of this form also gives my consent to the *New York University School-Based Cavity Prevention Program* to contact other providers that have examined my child and to obtain insurance information.

Time Period During Which Release of Information is Authorized:
From: Date that form is signed on opposite page
To: Date that student is no longer enrolled in the School-Based Oral Health Clinic

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