



Health Department  
**MULTNOMAH COUNTY**  
School and Community Oral Health  
10317 E Burnside St., 2<sup>nd</sup> Floor  
Portland, Oregon 97216-2733  
**503-988-3905**  
503-988-6240 fax

Dear parent or guardian:

There is a **FREE** dental program at **your child's school**. The program protects teeth from decay by putting a thin coating of plastic called **sealants**, on permanent teeth.

Sealants done last year need to be looked at to make sure they are still in place. Sealants needing repair will be fixed or replaced.

Your child's teeth will be looked at and sealants may be given. The procedure is very easy, with no more risks than a simple tooth cleaning.

**If you want your child to be checked and have sealants:**

- **complete the following form**
- **sign the form**
- **date the form**
- **return the form to school as soon as possible**



**Multnomah County Health Department  
School Dental Sealant Program  
503-988-3905**



Your child's school has been chosen to participate in the Multnomah County School Dental Sealant Program. A dental sealant is a coating that is 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) |
| My Child's School: _____ Grade: _____ Teacher: _____ |         |                  |

- YES**, I want my child to have a dental screening and dental sealants.
- NO**, I don't want my child to have a dental screening or get dental sealants.  
If no, please check the following to help us improve the program.
- My child's dentist will provide sealants.     Other (please describe): \_\_\_\_\_

**If yes, please COMPLETE and SIGN below**

|  |   |   |  |
|--|---|---|--|
| <b>Family Information</b>                    | Parent/Guardian: _____  |   |  |
|  | Daytime phone number: _____   | Child's date of birth: ____ / ____ / ____<br><small>Mo / Day / Year</small> |  |
|  | My child is taking (list medications): _____ <input type="checkbox"/> None  |   |  |
|  | My child is allergic to: _____ <input type="checkbox"/> None  |   |  |
|  | My child has:<br><input type="checkbox"/> Asthma <input type="checkbox"/> Behavioral considerations (please describe): _____  |   |  |
| <b>Insurance</b>                             | Health Insurance (check one)  |   |  |
|  | <input type="checkbox"/> Oregon Health Plan (OHP) / Medicaid ID# _____  |   |  |
|  | <input type="checkbox"/> Private Dental Insurance Company _____   |   |  |
| <input type="checkbox"/> No health insurance |   | These services are provided at no cost to you.                              |  |
| <b>Please Read</b>                           | If you said YES to screening and sealants, your signature below indicates:<br>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."<br>I also understand a dental student closely supervised by a licensed dental professional may provide treatment. |   |  |

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

\*\*\*\*\* FOR OFFICE USE ONLY\*\*\*\*\*

**I. SCREENING – Triage**

- 0** = No visible signs of oral problems. Please see your dentist at least yearly.
- 1** = Visible signs of oral problems were found. A dentist visit is recommended to prevent serious or more costly problems.
- 2** = Visible signs or symptoms of serious dental needs were found. An immediate visit to a dentist is recommended.

**II. SCREENING – Additional Information**

- Permanent teeth have cavities or fillings.
- Primary teeth have cavities or fillings.

**III. SCREENING AND SEALANT PLACEMENT**

| 2         |  | 3         |  | 14        |  | 15        |  |
|-----------|--|-----------|--|-----------|--|-----------|--|
|           |  |           |  |           |  |           |  |
|           |  |           |  |           |  |           |  |
|           |  |           |  |           |  |           |  |
|           |  |           |  |           |  |           |  |
|           |  |           |  |           |  |           |  |
| <b>31</b> |  | <b>30</b> |  | <b>19</b> |  | <b>18</b> |  |

|                                |                         |                         |        |
|--------------------------------|-------------------------|-------------------------|--------|
| <b>Number of teeth sealed:</b> | 1 <sup>st</sup> molars: | 2 <sup>nd</sup> molars: | Other: |
|--------------------------------|-------------------------|-------------------------|--------|

Provider's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Health History Review:  Data Entered:

Comments: \_\_\_\_\_

Referral / Notes: \_\_\_\_\_

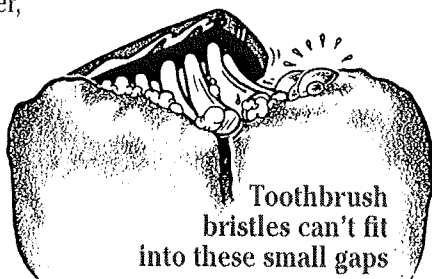


# Dental Sealants: Seal Out Decay . . . Seal In Smiles

## Now your children's teeth can benefit from a new kind of protection

Most cavities start on back teeth because they have many small gaps called "pits" and "fissures" where germs and food can hide and cause tooth decay. Teeth need protection from *cavities*.

Fluoride, in water, toothpaste, and mouth rinse is great for the sides of the teeth, but the tops of teeth have tiny gaps and need special protection.



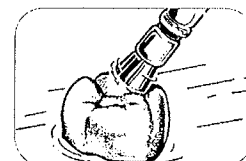
Everyday brushing and flossing help, but toothbrush bristles can't fit into those tiny crevices, and flossing only cleans the sides of your teeth.

NOW your children's teeth can be protected with a plastic coating called *sealant*. With dental sealants your child may never have a cavity or filling, and you'll probably have lower dental bills!

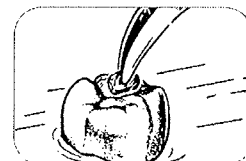
Sealant is a safe plastic coating which keeps germs out of the back teeth by covering up their hiding places. Sealants work and are easy to apply. There are no drills or needles involved!

## Applying Sealant . . . an Easy Three-Step Process

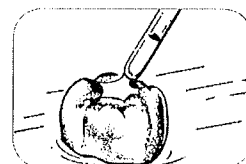
1. A dentist or dental hygienist cleans your child's teeth with a special toothpaste.



2. A special cleansing liquid, on a tiny piece of cotton, is gently rubbed on the teeth and is washed off in a minute.



3. Finally, the sealant is painted on the teeth. It takes about a minute for the sealant to form a protective shield.



## Seal Out Decay . . . Seal In Smiles

### Tips For Good Dental Health

- Seal out cavities with dental sealants
- Use fluoride – in supplements, toothpaste, and mouth rinse
- Brush at least twice a day
- Floss every day
- Eat well balanced meals and cut out sweets between meals
- Have regular dental checkups

**"Fewer cavities and fillings . . . lower dental bills . . . and big smiles!"**

Ask your family dentist about dental sealants • For more information, call 503-988-3905



Text and artwork originally developed by Columbus Health Department, Columbus Ohio, character originally designed by Character Builders, Columbus Ohio, Centers for Disease Control, Center for Prevention Services, Dental Disease Prevention Activity, Atlanta, Georgia. Used by permission.



## NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.  
**Please review it carefully.**

*This notice describes the privacy practices of Multnomah County Health Department. We are required by law to maintain the privacy of your protected health information ("Information") and to give you this notice. We are required to follow the terms of the notice currently in effect. This notice is effective on September 23, 2013. We reserve the right to change this notice. Any changes will apply to Information that we already have about you. We will post a current copy of this notice where services are provided and online at: [www.multco.us/hinaa](http://www.multco.us/hinaa)*

### YOUR RIGHTS

#### Inspect and Copy:

You have the right to inspect or copy your Information held in a "designated record set". A "designated record set" is a group of records that is used to make decisions about you. We may limit the Information that you can inspect or copy in limited circumstances. If we limit your right to inspect or copy, you can ask in writing for a review of that decision. Copies of records may be provided to you or a third party that you identify in an electronic or paper format depending on your request and the technology in which the records are maintained. Your request must be in writing. We can help you make a written request. We may charge you a fee for copies.

#### Amendment:

You have the right to ask us to change some of the Information in your designated record set that you believe is incorrect or incomplete. Your request must be in writing and provide a reason. We can help you make a written request. We will tell you in writing if we deny your request and you have the right to respond to our denial. You also have the right to have your request, the denial and a statement of disagreement, if any, included in future releases of your record.

#### Accounting:

You have the right to ask for a list of certain disclosures of your Information in your designated record set. The list will not include disclosures made for treatment, payment, or health care operations, disclosures made to you or individuals involved in your care or payment for care. It also will not include disclosures made prior to 6 years before the date of the request, pursuant to an authorization, as part of a limited data set, to a correctional facility, incidental disclosures, disclosures made for national security or intelligence, or disclosures made prior to April 14, 2003. Your request must be in writing. We can help you make a written request. We may charge you a fee if you ask for a list more than once every 12 months.

#### Limited Data Set:

We may disclose limited Information to third parties for purposes of research, public health or health care operations. This disclosure will not include any Information which can be used to directly identify you.

#### Incidental Disclosures:

Incidental disclosures of your Information may occur as a by product of permissible uses and disclosures. For example, a visitor to a service area may overhear your name called in a waiting area.

#### Required or Permitted by Law:

We may use or disclose your Information when permitted or required by federal, state or local law.

#### Marketing:

We may communicate with you face-to-face about products or services that may interest you or give you a promotional gift of nominal value. Otherwise, we do not use or disclose your Information for marketing without your authorization.

### DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

#### Other Laws Protecting Health Information:

Other laws may require your written authorization to disclose your Information about certain mental health, alcohol and drug abuse treatment, HIV/AIDS testing or treatment, and genetic testing. We must obtain authorization for the use and disclosure of psychotherapy notes and the sale of your Information.

Uses and disclosures other than those permitted will only be made with your written authorization. If you authorize us to use or disclose your Information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your Information for the purposes given in the written revocation. The revocation will not affect disclosures previously made in reliance on your authorization.

### FOR MORE INFORMATION

If you have any questions about this notice or need more information, please contact Multnomah County Privacy Officer, 426 SW Stark St., 7th Floor, Portland, OR 97204 or call 503-988-3674.



[www.mchealth.org](http://www.mchealth.org)

*The Multnomah County Health Department offers equal opportunity in services and employment.*

**Restrictions:**

You have the right to ask us to limit how your Information is used or disclosed. We are not required to accept your request and we may be unable to do so with one exception. You may request that your Information not be shared with a health plan when you or someone on your behalf pays for your service in full and the use or disclosure is for payment or health care operations and not otherwise required by law. Your request must be in writing. We can help you make a written request.

**Confidential Communications:**

You have the right to ask us to communicate with you at a certain place in a certain way. You must specify how or where you wish to be contacted. For example, you can ask that we only contact you at work. We will accommodate any reasonable request.

**Notice:**

You have the right to receive a paper copy of this notice upon request. This notice can be made available in other languages and alternative formats.

**Breach Notice:**

You have the right to be notified in the event that we discover a breach of unsecured Information.

**Complaints:**

You have the right to file a complaint if you believe we have violated your privacy rights. You may file a complaint with our Privacy Officer or with the Secretary of the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint.

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## HOW WE MAY USE AND DISCLOSE YOUR INFORMATION WITHOUT YOUR AUTHORIZATION

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**Treatment:**

We may use or disclose your Information as necessary to provide you with medical treatment and services. For example, we may disclose your Information to other health care providers involved in your treatment.

**Payment:**

We may use or disclose your Information to bill or receive payment for the services you receive. For example, to submit claims.

**Health Care Operations:**

We may use or disclose your Information for business operations. For example, we may use your Information in connection with conducting quality assessment and improvement activities and for case management services.

**Organized Health Care Arrangements:**

We participate in organized health care arrangements (OHCA) and may use or disclose your Information to members of those arrangements as allowed by the Health Insurance Portability and Accountability Act (HIPAA). In some circumstances, we use systems and services of OHCA members for electronic health records and treatment referral coordination. We may share your information with OHCA members for the joint health care operations of the OHCA.

**Individuals Involved in Your Care or Payment for Your Care:**

We may disclose Information to your family, personal representative or others involved in your care or payment for care if you give verbal permission or otherwise do not object. If you are unable to make a health care decision yourself, we may disclose your Information as necessary if we believe that it is in your best interest.

**Public Health Activities:**

We may use or disclose Information about you for public health activities. For example, disclosures made for the purpose of preventing or controlling disease, injury, disability, abuse or neglect. These activities include activities performed by organ or tissue donation and transplantation services, activities performed by coroners, medical directors, and funeral directors, and activities necessary to avoid a serious threat to the imminent health and safety of you or others.

**Health Oversight Activities:**

We may disclose Information to a health oversight agency. Activities include audits and inspections for the government to monitor the health care system.

**Legal Proceedings:**

We may disclose Information about you in response to a court order, subpoena, discovery request, activities related to workers' compensation benefits, or other lawful purpose.

**Law Enforcement:**

We may disclose Information about you to the police or other people who enforce the law when this disclosure is permitted or required by law. We may disclose Information to report a crime on our premises.

**Research:**

Under certain circumstances, we may use and disclose your Information for research approved by an Institutional Review or Privacy Board or through an authorization signed by you.

**Inmates:**

If you are an inmate of a jail or prison or under the custody of law enforcement, we may disclose Information as required or permitted by law.

**Business Associates:**

In certain situations, we may need to disclose your Information with a business associate, such as a translator or quality assurance reviewer, so it can perform a service on our behalf. We will have a written agreement with the business associate requiring it to protect the privacy of your Information under the same privacy protections that we provide.

**Military and National Security:**

We may disclose your Information as required by armed forces personnel or to federal officials authorized for national security and intelligence activities.

**Disaster Relief Efforts:**

Unless you object, we may disclose your Information to other health care providers or to an entity assisting in a disaster relief effort to coordinate care. We may disclose your Information as necessary to identify, locate and notify family members, guardians or others responsible for your care, location, condition or death.