RECRUITMENT LETTER and PARENTAL INFORMED CONSENT

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 with the NYU College of Dentistry. The program will provide twice each year, in-school, dental care to prevent cavities and toothaches. Licensed dentists, dental hygienists, and/or nurses will provide care to participating students.

This program is part of a NYU College of Dentistry research study, with funds from the Patient Centered Outcomes Research Institute, to determine the relationship between dental health and student achievement.

As part of the program your child's dental health records, school attendance records, and New York State standardized test scores will be provided to NYU College of Dentistry and used to assess program effectiveness for as long as your child is receiving dental preventive care through this program. We plan to provide the program for up to 5 years. Your child will not be identified by name in any analysis of the research that may be published.

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. Your child's Medicaid billing ID number will be used to link the oral health data collected in the school-based cavity prevention programs in NYC to Medicaid claims data.

If you consent to participation, your child will receive the cavity preventative care described below which may be identical to what would be provided in a dental office and is consistent with recommendations for cavity prevention from the U.S. Centers for Disease Control and Prevention.

The program provides:

1. Instruction on toothbrushing
2. An oral exam to check the teeth, gums, and mouth
3. Cavity prevention and control by either:
    - Sealants, temporary fillings, and fluoride varnish on all teeth, or
    - Silver diamine fluoride on the back teeth + fluoride varnish on all teeth
4. A toothbrush and toothpaste
5. A report to the school nurse, and to you, on your child's care
6. Referral to a dentist for further care (if needed), and assist you in finding a local dentist (if needed)
7. The program will follow your child over time (up to five years) to check that his/her oral health is improving
8. If you need a dentist you can find one nearby here: https://www1.nyc.gov/site/doh/health/health-topics/oral-health-find-a-low-cost-dental-provider.page

There are no known health risks to cavity prevention. Please note that if your child participates in the program, the application of silver diamine fluoride may discolor any cavities resulting in a brown or black color. This change in color means that the cavity has stopped growing. If accidental skin contact occurs it can cause a temporary light brown staining to the lips, cheeks, or permanent staining to clothing. For stain removal to the skin apply soap and water immediately. Do not use excessive methods in an attempt to remove difficult stains from the skin, as the stains will eventually fade. Use the same procedure for cleaning clothes.

If you consent, to your child's participation in the program, please complete, sign, and return the attached form. You can participate or withdraw at any time. If guardianship of your child changes during this time, a new informed consent will need to be signed.

If you have any questions about this program you may contact: 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. You may also contact the New York University Institutional Review Board (IRB), 665 Broadway, Suite 804, New York, NY 10012. Email: ask.humansubjects@nyu.edu. Phone: 212-998-4808.

Best wishes,

_____

[Insert Name], Principal

Approved For Period: 2/5/2019 – 5/14/2019

New York City Department of Education Oral Health Clinic Program - School Parental Consent Form

NEW YORK UNIVERSITY COLLEGE OF DENTISTRY **(OHCP)**

345 E 24TH ST, NEW YORK, NY 10010 **(OHCP Address)**

STUDENT INFORMATION

Student's Last Name:

Student's First Name:

Date of Birth: ___ / ___ / ____
Month ***Day*** ***Year***

Student Address:

City: ***State:*** ***Zip Code:***

School:

Teacher's Name: **Grade:**

IMPORTANT MEDICAL QUESTION

Does your child have any medical condition that may affect or complicate dental treatment? This may include heart, breathing or bleeding issues, seizures, allergies (including allergies to silver and nuts), communicable diseases, immune disorders, etc. If Yes, explain. IF NO, LEAVE BLANK

PARENT/ GUARDIAN INFORMATION

Mother's Last Name: **Mother's First Name:**

Father's Last Name: **Father's First Name:**

If Applicable, Legal Guardian's Last Name:

Legal Guardian's First Name: **Relationship of guardian to student:**
☐ Grandparent ☐ Aunt or Uncle ☐ Other

Contact Information for parent or guardian

Home Tel: ___ - ___ - ____ **Work Tel.** ___ - ___ - ____

Cell: ___ - ___ - ____

Email:

Additional Emergency Contact

Name:

Home Tel: ___ - ___ - ____ **Work Tel.** ___ - ___ - ____

Cell: ___ - ___ - ____ **Relationship to student:**

Email:

For Office Use Only

Version 6.0 1.14.2019

INSURANCE INFORMATION

Does your child have Medicaid? ☐ No ☐ Yes: Medicaid ID #:

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

Which Plan? ☐ Fidelis ☐ Health Plus Amerigroup ☐ MetroPlus ☐ United Healthcare ☐ Empire BlueCross BlueShield ☐ Affinity ☐ Healthfirst ☐ HIP ☐ WellCare ☐ MVP ☐ Other:

Does your child have coverage through an employer based plan or other type of health insurance? ☐ No ☐ Yes, Health Plan:

Member ID or Social Security Number:

Health Insurance Phone Number: - -

Name of Insured Adult:

Birth Date of Insured Adult: / / (Month / Day / Year)

Services will be provided to your child regardless of whether or not your child has health insurance, at no cost.

PARENTAL CONSENT FOR SCHOOL BASED HEALTH CLINIC SERVICES

I have read and understand the attached Recruitment Letter and consent to my child receiving oral health services and participating in the NYU College of Dentistry preventive care and research program. My signature provides consent for my child to receive services provided by the OHCP for the 5 years of this program. Furthermore, I consent to the release of my child's dental health records, school absence records, and New York State standardized test scores for use in this research program. I may withdraw my consent at any time by written notice to OHCP. I understand that I will report any significant changes in my child's health to the provider.

Signature of Parent/Guardian (or student if 18 years or older)

Date: / / (Month / Day / Year)

HIPAA 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 health information as specified

Signature of Parent/Guardian (or student if 18 years or older)

Date: / / (Month / Day / Year)

CONSENT FOR 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 OHCP as part of the school oral health program approved by the New York State Department of Health for as long as my child is enrolled at school. I may withdraw my consent at any time by written notice to the OHCP. I understand that confidentiality between the student and the oral health clinic provider will be ensured for specific service areas in accordance with the law, and that students will be encouraged to involve their parents/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 services, and emergency procedures. Preventative oral health services include, but are not limited to, comprehensive dental exams, temporary fillings, dental hygiene treatments, sealants and fluoride treatments. This may also include the application of silver diamine fluoride (SDF) on back teeth. Silver diamine fluoride may discolor any cavities resulting in a brown or black color. Accidental skin contact can cause a temporary light brown staining to the lips, cheeks, or permanent staining to clothing. For stain removal to the skin apply immediately with soap and water. Do not use excessive methods in an attempt to remove difficult stains from the skin, as the stains will eventually fade. Use the same procedure for cleaning clothes.

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF ORAL HEALTH INFORMATION

My signature on this form authorizes the release of health information. This information may be protected from disclosure by federal privacy law and state law. By signing this consent, I am authorizing health information to be released to the Board of Education of the City of New York (a/k/a New York City Department of Education), which may include school nurses, because it is required by law, Chancellor's regulation, because it is necessary to protect the health and safety of the student, or in order to process a claim with my child's insurance provider. Upon my request, the facility or person disclosing this 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 the release of my child's health information, and that I can change my mind at any time and revoke my authorization by writing to the OHCP. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation. I authorize the OHCP to release specific health information on 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 OHCP to the NYC Department of Education and from the NYC Department of Education to the OHCP, of health information outlined below in order to meet regulatory requirements and to 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:**

- 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 OHCP to contact other providers that have examined my child and to obtain insurance information. The Release of Information is authorized from the date that form is signed until the student is no longer enrolled in the School Based Oral Health Clinic Program or until revoked, whichever is earlier.

Patient Rights and Privacy Policy shall be provided by the OHCP, as applicable by law.

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Accessibility Report

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