NYC Department of Education Oral Health Clinic Program - School Parental Consent Form
Columbia University College of Dental Medicine, 622 W 168th St, New York, NY 10032

____ *(School(s) Covered)*

____ *(School Address)*

STUDENT INFORMATION

Student's Last Name: ______________________

Student's First Name: ______________________

Date of Birth: ________ / ________ / ________
Month *Day* *Year*

Student Address: ______________________

____
City *State* *Zip Code*

School: ______________________**Grade:**________

Teacher's Name: ______________________

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, communicable diseases, immune disorders, etc. If Yes, explain. IF NO, LEAVE BLANK

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____

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
Grandparent ❑ Aunt or Uncle ❑ 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?
❑ No ❑ Yes: Medicaid ID # ______________________

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

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

❑ 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: ______________________
Name of Insured Adult: ______________________
Birth Date of Insured Adult: ______________________

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 understand that my child will be receiving oral health services and my signature provides consent for my child to receive services provided by Columbia University College of Dental Medicine for as long as my child is enrolled in school. I may withdraw my consent at any time by written notice to Columbia University College of Dental Medicine. **I understand that I will report any significant changes in my child's health to the provider.**

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.

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

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

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

Columbia University College of Dental Medicine, 622 W 168th St, New York, NY 10032
NEW YORK CITY DEPARTMENT OF EDUCATION
ORAL HEALTH CLINIC PROGRAM

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 Columbia University College of Dental Medicine 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 Columbia University College of Dental Medicine. 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, dental hygiene treatments, x-rays, sealants and fluoride treatments. This may also include the application of Silver Diamine Fluoride on back teeth to halt the progression of cavities (Silver Diamine Fluoride may discolor any cavities resulting in a brown or black color). For services other than comprehensive dental exams and preventative oral health services, Columbia University College of Dental Medicine shall notify the parent/guardian of the services and treatments to be provided including fillings, extractions, and the use of anesthetics or other medications. If the parent/guardian does not consent, these services shall not be performed.

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF ORAL HEALTH INFORMATION

My signature on the reverse side of 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 Columbia University College of Dental Medicine. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

I authorize Columbia University College of Dental Medicine 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 Columbia University College of Dental Medicine to the NYC Department of Education and from the NYC Department of Education to Columbia University College of Dental Medicine, 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 1 of this form also gives my consent to Columbia University College of Dental Medicine 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 Columbia University College of Dental Medicine, as applicable by law.**

Accessibility Report

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Organization:

Summary

The checker found no problems in this document.

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- Passed manually: 0
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- Skipped: 1
- Passed: 29
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