Our dental clinic is coming to your school!

No Cost Dental Care

Complete this paper form or scan this QR code to sign up!

Has your child received preventative dental care in the last 12 months? If you answered yes, we do not want to interrupt care in their dental home. Please do not sign up if your child is currently receiving routine dental care. Eligibility will be prioritized according to need. **Services may include:** Exam, Visual Assessment, X-Rays, Cleaning, Fluoride Varnish, SDF, Povidone Iodine Antiseptic Oral Swab (PVP-I), Oral Hygiene Instruction, Nutritional Counseling, and Sealants.

Student's Legal Name:		**Student's Birthdate (mm/dd/yyyy)** / /	**Gender:** F ☐ M ☐ O ☐
Home Address:		**City/State:**	**Zip:**
School:	**Teacher:**	**VPK ONLY** Full Day Early Release	**Grade:**
Parent or Guardian Name:	**E-Mail:**	**Phone:** ( ) -	

Important Health Questionnaire | Please be thorough and provide the information requested.

Does your child have any allergies, medical, or behavioral health conditions?
☐ No ☐ Yes, explain:

Is your child enrolled in the free and reduced lunch program? ☐ No ☐ Yes

Does your child have any dental problems or have they been told they need an antibiotic premedication prior to dental treatment?
☐ No ☐ Yes, explain:

Are they in your care due to a foster care arrangement? ☐ No ☐ Yes

Does your child take any over-the-counter (OTC) and/or prescribed (RX) medications?
☐ No ☐ Yes, explain:

Is there anything else we should know about your child that will allow us to better provide dental services for them?
☐ No ☐ Yes, explain:

Child's Dental Insurance? No Insurance Medicaid Florida Kid Care DentaQuest MCNA Other:

Have they seen a dentist in the last year? ☐ No ☐ Yes **Name of dentist and date of last appointment:**

If yes, please circle the reason for the visit: **Cleaning Pain Filling Extraction CVHN Dental Clinic at your child's school**

I represent and warrant that the information provided in the above health questionnaire is accurate to the best of my knowledge. I understand and acknowledge that Children's Volunteer Health Network, Inc. (CVHN) will develop my child's treatment plan based upon the information that I have provided herein. Should any injury arise as a result of any error or inaccuracy in the information provided herein, I, in my individual capacity and on behalf of my child, release CVHN, its agents, employees, directors, officers, agents, successors, and assigns from any and all liability and hereby indemnify and hold CVHN, its agents, employees, directors, officers, agents, successors, and assigns harmless from any claims, demands, actions, suits, damages, liabilities, losses, settlements, judgments, costs, and expenses arising therefrom.

Media Release: I hereby give permission to Children's Volunteer Health Network, Inc. (CVHN), located in Santa Rosa Beach, Florida, to use photographs, videos, and/or written or verbal statements that include my child and/or me for promotional, educational, fundraising, advertising, or other lawful purposes. This includes use in printed materials, websites, social media, newsletters, and other publications or media.

I understand and agree that these materials may be used by CVHN alone or in partnership with other organizations, and that they may include likenesses, personal stories, and general information related to our experience with CVHN. I voluntarily waive any rights to confidentiality or compensation and release CVHN from any liability related to the use or sharing of this media. ☐ OPT OUT of Media Release.

Please read and sign to complete your student's enrollment: I request Children's Volunteer Health Network (CVHN) to perform preventative dental care for my child, which may include exams, visual assessments, x-rays, prophylaxis, fluoride varnishes, povidone iodine antiseptic oral swabs (PVP-I), oral hygiene instructions, nutritional counseling, sealants, and silver diamine fluoride (SDF) applications. ☐ OPT OUT of SDF applications. I understand at any time I may choose that my child receive care from another dental provider rather than from CVHN. I have read the IMPORTANT HEALTH QUESTIONNAIRE above and have provided all information as requested, and will report any changes as they come up by calling 850-461-0329. By signing this form, I give permission for CVHN to communicate with me via phone/text/email/mail/writing regarding anything relating to my child's treatment. I have read the IMPORTANT NOTICE & CONSENT included with this form, and I understand and agree to its terms. By signing the consent, the parent/guardian consents to the disclosures contained in the uses and disclosures of health information contained in this form.

I, the undersigned, hereby acknowledge and agree to the following: I understand that the proposed dental treatment involves certain risks, including but not limited to infection, bleeding, pain, and damage to surrounding tissues. I have been informed of the potential risks, benefits, and alternatives associated with the proposed treatment, and I have had the opportunity to ask questions and seek clarification. I understand that the outcome of the treatment cannot be guaranteed, and that unforeseen complications may arise during or after the procedure. I voluntarily consent to the proposed dental treatment, understanding the risks involved, and I release the dental practitioner and their staff from any liability arising from the performance of the treatment. I understand that I have the right to refuse or withdraw consent for the treatment at any time, and that I may seek a second opinion if desired.

In consideration of services provided by the CVHN, I hereby release and agree to save harmless CVHN its directors, instructors, employees and students, and any other person connected with the services from any and all claims, damages, and causes of action that may arise from provision of the services described above, and from any other care provided while I am (or my child is) a patient of CVHN.

SIGN HERE

Signature of Parent/Legal Guardian: **Date: (MM/DD/YYY)** / /

Important Notice and Consent: I understand that as part of my child's care, Children's Volunteer Health Network (CVHN) originates and maintains health records describing health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care. I hereby authorize CVHN's dentists, dental hygienists, dental assistants, and other medical personnel to administer the services outlined in this form, which may include exams, visual assessments, x-rays, prophylaxis, fluoride varnishes, povidone iodine antiseptic oral swabs (PVP-I), oral hygiene instructions, nutritional counseling, sealants, and silver diamine fluoride (SDF) applications. I understand that while adverse reactions are rare, preventative dental products may cause allergic responses.

Silver Diamine Fluoride (SDF) Disclosure: SDF is an antimicrobial liquid used to slow or stop tooth decay and relieve sensitivity. It is applied directly to the affected area and may be reapplied every 6–12 months or as advised. **Benefits:** slows or stops tooth decay, may reduce tooth sensitivity. **Risks:** Decayed areas will permanently stain black; healthy areas will not, fillings and crowns may discolor at the edges, temporary gum or skin staining (clears in 1–3 weeks), brief metallic taste may occur. **Limitations:** SDF does not restore tooth function or appearance, fillings or crowns may still be needed. **Contraindications:** Not suitable for children with silver allergies or open sores in the mouth. **Alternatives:** Fluoride varnish, fillings, crowns, or extractions, which may require sedation or anesthesia. SDF is safe and effective, but results are not guaranteed. Additional treatment may be needed if decay progresses. If you do not want your child to receive SDF application, please check the "OPT OUT of SDF" box on the front page of this form.

Unless I have made prearrangements to attend and am present at the time of service, I understand these services will be provided without my presence. For questions about the benefits or risks of care, I may contact CVHN at the number provided. We may send you text messages about the program.

Message and/or data fees may be charged to your wireless service provider; to discontinue, reply "STOP" to any message received from us. I also agree to receive pre-recorded and/or auto-dialed telephone calls relating to the school dental program at the landline and/or mobile telephone numbers provided on this consent form. I have received the Notice of Uses and Disclosures of Health Information included in this form and consent to the release of my child's medical record information, including records obtained from other providers, and any disease, drug and alcohol and anemia information.

I authorize release of such information by provider to any responsible payor and/or administrative service provider and their subcontractors for use and disclosure relating to my child's treatment, payment for services and health care operation purposes .I hereby give permission to Children's Volunteer Health Network, Inc. (CVHN), located in Santa Rosa Beach, Florida, to use photographs, videos, and/or written or verbal statements that include my child and/or me for promotional, educational, fundraising, advertising, or other lawful purposes. This includes use in printed materials, websites, social media, newsletters, and other publications or media.

I understand and agree that these materials may be used by CVHN alone or in partnership with other organizations, and that they may include likenesses, personal stories, and general information related to our experience with CVHN. I voluntarily waive any rights to confidentiality or compensation and release CVHN from any liability related to the use or sharing of this media. If If you do not wish for your child's photo or video to be used, please check the "OPT OUT of media release" box on the front page of this form.

I expressly agree that this Consent is intended to be as broad and inclusive as permitted by state law. I further agree that in the event any clause or provision of this Consent is held invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not otherwise affect the remaining clauses or provisions of this Consent, which shall continue to be enforceable.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment and health care operations. For example:

- **Treatment:** We may use or disclose your child's health information to a physician, school nurse or other health care provider providing treatment to you.
- **Payment:** We may use or disclose your child's health information to obtain payment for the services we provide to you. However, at this time CVHN does not bill for any services rendered.
- **Health Care Operations:** We may use and disclose your child's health information in connection with our business operations, such as reviewing the competence or qualifications of health care professionals and evaluating practitioner and provider performance. I understand that as part of my child's care, CVHN may share relevant health or treatment information with school personnel including, but not limited to, the principal(s), school nurse(s), teacher(s), guidance counselor(s), school aides, office staff, and school district administration to support my child's care on campus.

Your Authorization: Uses or disclosures not otherwise described in this notice may be made only with your written authorization. In addition, we must obtain your written authorization to sell your child's medical information or to use or disclose your child's information for marketing goods or services to you in which we are paid to make the communication. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your child's medical information for any reason except those described in this notice.

To Your Family and Friends and Persons Involved in Your Care: We may disclose your child's health information to a family member, friend or other person involved in your child's care to the extent necessary to help you with your child's health care or with payment for your child's health care. We may also disclose your child's medical information to disaster relief organizations to help locate individuals during a disaster. We may also use or disclose your child's medical information to notify or assist in the notification of a family member, a personal representative or a person responsible for your child's care of your child's location, general condition or death. If you do not want us to disclose your child's medical information to family members or others in these circumstances, please notify our HIPAA officer at (850) 461-0329.

Required by Law: We may use or disclose your health information when we are required to do so by law. This includes responding to any warrant or subpoena for medical records from any federal, state, or local law enforcement agency, including U.S. Immigration and Customs Enforcement.

Public Safety: We may need to disclose medical information to law enforcement officials, such as in response to a search warrant or a grand jury subpoena, or to assist law enforcement officials in identifying or locating an individual, to report deaths that may have resulted from criminal conduct and to report criminal conduct on our premises.

Abuse or Neglect: We may disclose your child's health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your child's health information to the extent necessary to avert a serious threat to your child's health or safety or the health or safety of others.

National Security: We may disclose your child's medical information to military authorities of armed forces or foreign military personnel under certain circumstances, to authorized federal officials for lawful intelligence, counterintelligence or other national security activities, and to protect the president, and to a correctional institution or law enforcement official having lawful custody of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your child's health information to provide you with appointment reminders, such as voicemail messages, postcards, letters emails or text messages.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure surveys. These activities are necessary for the government to monitor the health care system, the outbreak of disease, government programs, compliance with civil rights laws and to improve patient outcomes.

Lawsuits and Disputes: We may disclose health information about you in response to a court administrative order. We may also disclose health information about you in response to a subpoena, discovery process or other lawful process.

Other Uses and Disclosures:
As permitted or required by law, we may use or disclose your child's medical information for research purposes to organizations that handle and monitor organ donation and transplantation; for workers' compensation or similar programs that provide benefits for work-related injuries or illness; for public health activities such as to prevent or control disease, injury or disability, to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to, or is at risk for contracting or spreading a disease; to medical examiners to identify a deceased person or determine cause of death; or to funeral directors to carry out their duties.

Patient Rights

Access: You have the right to look at or get copies of your child's health information, with limited exceptions. You must make a request in writing to obtain access to your child's health information and email your request to the e-mail at the end of this notice.

Restriction: You have the right to request that we restrict our use or disclosure of your child's health information. We are not required to agree to your request, except when the disclosure would be to your child's health plan (or someone acting on your behalf other than your child's health plan) and you or that person has paid in full for your child's health care, the disclosure relates to payment or health care operations, and the disclosure is not otherwise required by law. If we agree to the restriction, we will abide by it except in an emergency.

Alternative Communication: You have the right to request in writing that we communicate with you about your child's health information by alternative means or to alternative locations specified in your written request.

Amendment: You have the right to request that we amend your child's health information. Your request must be in writing and must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our website or by email, you are entitled to receive this notice in written form upon request.

Statute 466.024 Section 3a & 3b of The Florida Department of Health: (a) The services being offered are not a substitute for a comprehensive dental exam by a dentist. (b) The diagnosis of caries, soft tissue disease, oral cancer, temporomandibular joint disease (TMJ), and dentofacial malocclusions will be completed only by a dentist in the context of delivering a comprehensive dental exam.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your child's privacy rights, you may complain to us by using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Christina Peterson, RDH
Phone: 850-622-3200
Email: dental@cvhnkids.org
Mailing Address: P.O. Box 2142
Santa Rosa Beach, FL 32459
Web: www.cvhnkids.org
Effective Date: May 15, 2025