NYU | DENTISTRY

CHILDREN'S DENTAL PROGRAM CONSENT FORM

NYU College of Dentistry is pleased to bring your child **preventive dental services at no out of pocket cost.** Dental treatment will be provided by NYU dental students and pediatric dental residents under faculty supervision.

Child's Name: _____ Date of Birth (MM/DD/YY): _____

School: _____ Teacher: _____

WHAT YOU NEED TO KNOW:

- **The services are offered at no out-of-pocket cost to you.** If your child has dental insurance/Medicaid, please provide this information for billing purposes. NYU Dentistry **will not** deny care to any child due to lack of insurance. Billing for services allows us to provide care to all children, regardless of coverage.
- **Your presence is not required at your child's dental visit**. Your child will be examined during school hours and a note will be sent home regarding any follow-up needs.
- By providing consent, you are granting permission for your child to participate in the activities outlined below for the duration of his/her attendance at Hudson City Schools. You may withdraw consent at any time by contacting your child's school or NYU Dentistry.
- I understand that NYU Dentistry must maintain the privacy of my protected health information by law according to HIPAA, and a copy of NYU Dentistry's Notice of Privacy Practices was made available to me through my child's school. The notice explained how my health information may be used and disclosed by NYU Dentistry, and how I may obtain a copy of this information and correct errors in my health information.

RMS OF CONSENT: By checking "yes" and signing below, I voluntarily consent to my child's participation in this dental program, meaning I horize the examination and treatment of my child's teeth by students, residents, and faculty from NYU Dentistry. I understand that:

Treatment may include application of fluoride in the form of fluoride varnish and silver diamine fluoride, and sealants.
I am not required to be present for my child's dental visit and that such treatment may be provided to my child during school hours.
I give permission to NYU Dentistry and its partners to photograph or film my child and to use any such photographs or footage for all purposes and in all media, including promotional materials and educational materials for the purposes of teaching, training, and research.
I authorize information about my child's health to be shared between NYU Dentistry and my child's school, who may then disclose this information for treatment, payment and healthcare purposes, including, but not limited to, the release of information to another healthcare provider in cases of patient referral and any financial sponsor (including the Department of Health and/or Medicaid) as may be required for payment for my child's treatment.
This information will remain confidential in accordance with Federal and State law. The dental record and its contents are the property of NYU Dentistry and may be made available to you upon written request to NYU Dentistry Global Outreach, 137 East 25th Street, Room 505 New York, NY 10010.

DECLARATION OF CONSENT

☐ **YES!** I consent to my child's participation in the NYU Dentistry School-Based Dental Program.

☐ **NO.** I do not consent to my child's participation in the NYU Dentistry School-Based Dental Program.

knowledgement: I am the parent/legal guardian of the child named below. I have read and understand the above nsent and by signing below I agree to its terms.

lationship to Child: _____ Phone Number (best contact): _____

_____

nt your name (above this line) **Signature** (Please sign above this line) **Date**