

FREE DENTAL SERVICES AT YOUR CHILD'S SCHOOL

Important: Please return a signed permission slip to use this free service.

Services include:

- Free dental screening: Our dental professional looks in the student's mouth to check the overall health of teeth and gums.
- Free dental sealants: Coatings put on the student's back teeth to prevent cavities.
- Free Fluoride: Brushed on teeth, this vitamin makes teeth stronger and prevents cavities.



Why you should sign your child up for free services:

- Healthy teeth are important to your overall health.
- When dental sealants are done in school, you miss less work, and your child misses less school.
- Dental sealants are done by dental care professionals.
- See your dentist at least once a year.



Fluoride is put onto teeth with a small brush.

For more information,
please call us at
503-521-7166.

Before Sealant



After Sealant



The Problem: Cavities

- Cavities are the most common childhood disease.
- About 50% of children aged 5-11 years have at least one cavity¹.

The Solution: Dental Sealants

- Students who receive sealants have 50% fewer cavities than students who do not².
- Fluoride application prevents 43% of cavities in permanent teeth and 37% of cavities in baby teeth³.

¹ CDC. Children's Oral Health. [https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html#:~:text=More%20than%20half%20of%20adolescents,one%](https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html#:~:text=More%20than%20half%20of%20adolescents,one%20)

² Community Preventive Services Task Force. (2017) Improving Oral Health: School-Based Dental Sealant Delivery Programs. <https://www.thecommunityguide.org/sites/default/files/assets/OnePager-OralHealth-School-Sealants.pdf>

³ Marinho VCC, Worthington HV, Walsh T, Clarkson JE. Fluoride varnishes for preventing dental caries in children and adolescents. *Cochran Database of Systematic Reviews* 2013, Issue 7. Art. No: CD002279. DOI: 10.1002/14651858

တၢ်တိစၢၤမၤစၢၤတဖၣ်လၢမဲအဂီၢ်လၢအပူၤကလီ အလံာ်ပျဲဖှိတ်



တၢ်သမံသမိးမၤကွၢ်မဲတဖၣ်, တၢ်ဒၢန့ၢ်ကွၢ်မဲကသံၣ်ကးတံာ်တဖၣ် ဒီးတၢ်ဖူလီဖလီရဲးတဖၣ် လၢအပူၤကလီန့ၢ် တၢ်မၤန့ၢ်အီၤလၢနဖီအကူၤသ့န့ၢ်လီၤ. တၢ်တိစၢၤမၤစၢၤတဖၣ်အံၤန့ၢ် ဘၣ်တၢ်မၤအီၤလၢ မဲကသံၣ်သရၣ်စ့ၣ်နီၤတဖၣ် ဒီးကဒိသဒါစၢၤကိာ်ပူၤတၢ်ဆါတဖၣ်န့ၢ်လီၤ.

ဖိသၣ်အမံၤ - _____
 (မံၤကတၢၢ်) (မံၤဒိၣ်ထံး) (မံၤလၢအဘၣ်သး)

ဖိသၣ်အိၣ်ဖျၢၣ်မုၢ်နံၤ (လၢ/နံၤ/နံၣ်) - _____ / _____ / _____ သရၣ် - _____ အတီၤ - _____

ကို - _____

မၤနီၣ်တၢ်လွၢ်န့ၢ်တခါလၢလံာ်အံၤ ဒ်သိးကဆဲးလီၤမံၤလၢ တၢ်တိစၢၤမၤစၢၤအပူၤကလီအံၤအဂီၢ်တက့ၢ် -

- မ့ၢ်, လၢတၢ်သမံသမိးမၤကွၢ်, မဲကသံၣ်ကးတံာ်တဖၣ်ဒီးဖလီရဲးအဂီၢ်
 - မ့ၢ်, လၢတၢ်သမံသမိးမၤကွၢ်ဒီး မဲကသံၣ်ကးတံာ်တဖၣ်အဂီၢ်
 - မ့ၢ်, လၢတၢ်သမံသမိးမၤကွၢ်ဒီး ဖလီရဲးအဂီၢ်
 - မ့ၢ်, ထဲလၢတၢ်သမံသမိးမၤကွၢ်အဂီၢ်
- * တၢ်နီၣ် - မ့ၢ်အါန့ၢ် "မ့ၢ်" တၢ်လွၢ်န့ၢ်တခါ ဘၣ်တၢ်မၤနီၣ်အီၤန့ၢ်, တၢ်ကဟ့ၣ်လီၤ တၢ်တိစၢၤမၤစၢၤလၢတၢ်အာၣ်လီၤဟ့ၣ်အီၤ ခဲလၢန့ၢ်လီၤ.

မၤတဂ့ၢ်, တဘၣ်ဟ့ၣ်တၢ်တိစၢၤမၤစၢၤနီၣ်တမံၤ လၢယဖိအဂီၢ်တဂ့ၢ်

တၢ်ဆဲးကျိးတၢ်ဂ့ၢ်တၢ်ကျိၤ	
မိၢ်ပၢ်/ပုၤကွၢ်ထွဲဖိ -	
လီၤတဲစိနီၣ်ဂီၢ်အဂ့ၢ်ကတၢၢ် လၢကဆဲးကျိးန့ၢ်အဂီၢ် -	တၢ်ဟ့ၣ်ပျဲလၢကဆုၢ်လံာ်အဂီၢ် - <input type="checkbox"/> ဟ့ၣ်တၢ်ပျဲလီၤ <input type="checkbox"/> တဟ့ၣ်တၢ်ပျဲဘၣ်
အံၤမ့ၢ်(လ)	
လီၤဆိးထံးလၢတၢ်ဆုၢ်လံာ်ပရၢအဂီၢ် -	

ဝံသးစူၤဟ့ၣ်ဘၣ် တၢ်ဂ့ၢ်တၢ်ကျိၤလၢအပိာ်ထွဲထီၣ်အခံဒ်သိး ပတိစၢၤမၤစၢၤနဖီကသ့ ဂ့ၤဒိၣ်န့ၢ်အဂီၢ်တက့ၢ် -

ယဖိန့ၢ်အီၤဝဲ (ကွဲးရဲၣ်လီၤကသံၣ်ကသီတဖၣ်) -	တအိၣ်ဘၣ် - <input type="checkbox"/>
ယဖိန့ၢ်တဘၣ်လိာ်သးဒီး -	တအိၣ်ဘၣ် - <input type="checkbox"/>
ဆူၣ်ချ့တၢ်ကူစါတၢ်အိၣ်သးခဲအံၤအိၣ်တမံၤမဲၤမဲၤ -	တအိၣ်ဘၣ် - <input type="checkbox"/>
တၢ်လၢကဘၣ်ဆိကမိၣ် ဘၣ်သးဒီး သးအဆူၣ်ချ့တၢ်ဟူးဂဲၤ အိၣ်တမံၤမဲၤမဲၤ -	တအိၣ်ဘၣ် - <input type="checkbox"/>
တၢ်ဂ့ၢ်တၢ်ကျိၤအဂၤလၢ ကမၤစၢၤပုၤဒ်သိး ကတိစၢၤမၤစၢၤနဖီ ဂ့ၤဒိၣ်ထီၣ်အဂီၢ် -	တအိၣ်ဘၣ် - <input type="checkbox"/>

ဝံသးစူၤကွဲးန့ၢ်မၤပုၤတၢ်နီၣ်ဖးလၢလံာ်အံၤတက့ၢ်. တမ့ၢ်နကဒီးန့ၢ်ဘၣ် တၢ်ယုအဘူးအလဲလံာ်ဘၣ်.

ဆူၣ်ချ့တၢ်အုၣ်ကီၤ - <input type="checkbox"/> Oregon Health Plan (OHP) / Medicaid ID# _____ <input type="checkbox"/> မဲဆူၣ်ချ့တၢ်အုၣ်ကီၤခီပနံၣ် လၢအပူၤဖျဲးဒီးပဒိၣ်ပပုၤကရၢကရိတဖၣ် _____ <input type="checkbox"/> ဆူၣ်ချ့တၢ်အုၣ်ကီၤတအိၣ်ဘၣ်	တၢ်တိစၢၤမၤစၢၤတဖၣ်အံၤမ့ၢ် အပူၤကလီန့ၢ်လီၤ.
ဒ်မိၢ်ပၢ်/ပုၤကွၢ်ထွဲဖိလၢအဖိးသဲးအသိး, ဖဲအံၤယတူၢ်လိာ်ဟ့ၣ်ခွဲး လၢတၢ်ကဟ့ၣ်လီၤရဲၤလီၤဒီးဟ့ၣ်ခီဟ့ၣ်နီၤ. တၢ်ဂ့ၢ်တၢ်ကျိၤ ပာ်ဃုာ်ဒီးကယါနီၢ်တဂၤဆူၣ်ချ့တၢ်ဂ့ၢ်တၢ်ကျိၤ, လၢပုၤဒၢန့ၢ်မဲကသံၣ်ကးတံာ်, ကိုအပူၤမၤတၢ်ဖိ, ပုၤဖိတၢ်အုၣ်ကီၤတဖၣ်, ဖိသၣ်အမဲကသံၣ်သရၣ်, တၢ်ကဟ့ၣ်ကယာ်ကရၢကရိလၢအဘၣ်ထွဲမၤသကိးတၢ်တဖၣ်, ဒီး/မ့တမ့ၢ် တၢ်ကဟ့ၣ်ကယာ်မဲကရၢကရိ လၢအမၤနီၣ်တၢ်တဖၣ်အဘၣ်စၢၤန့ၢ်လီၤ. ယဒီးန့ၢ်ဘၣ် လံာ်ကွဲးဒိဘၣ်ထွဲဒီး "နီၢ်တဂၤတၢ်ဂ့ၢ်ခူသ့ၣ်တၢ်မၤလုၢ်လိာ်တၢ်ဘိးဘၣ်သ့ၣ်ညါတဖၣ်" လဲန့ၢ်လီၤ. နီၢ်တဂၤတၢ်ဂ့ၢ်ခူသ့ၣ်တၢ်မၤလုၢ်လိာ်တဖၣ် တၢ်မၤန့ၢ်အီၤသ့လၢ All Smiles Community Oral Health အပုၤယဲၤသန့ AllSmilesCOH.org/forms န့ၢ်လီၤ.	
မိၢ်ပၢ်/ပုၤကွၢ်ထွဲဖိအတၢ်ဆဲးလီၤမံၤ - _____ မုၢ်နံၤ - _____	

Permission Slip for Free Dental Services



Free dental screenings, sealant placements, and brushed-on fluoride are offered at your child's school. These services are done by dental care professionals and will help prevent cavities.

Name of Child: _____		
(Last)	(First)	(Preferred Name)
Child's Date of Birth (mm/dd/yy): ____ / ____ / ____ Teacher: _____ Grade: _____		
School: _____		

Check ONE BOX below to sign up for this free service:

- Yes, to screening, sealants and fluoride
- Yes, to screening and sealants
- Yes, to screening and fluoride
- Yes, to screening only

* NOTE: If more than one "yes" box is checked, all approved services will be provided.

NO, do not provide any dental services for my child

Contact Information	
Parent/Guardian: _____	
Best phone number to reach you: _____	Permission to Text: <input type="checkbox"/> YES <input type="checkbox"/> NO
Email address: _____	
Mailing address: _____	

Please provide the following information so we can better serve your child:

My child is taking (list medications): _____	None: <input type="checkbox"/>
My child is allergic to: _____	None: <input type="checkbox"/>
Any current medical conditions: _____	None: <input type="checkbox"/>
Any behavioral considerations: _____	None: <input type="checkbox"/>
Other information to help us better serve your child: _____	None: <input type="checkbox"/>

Please complete the section below. You will not receive a bill.

Health Insurance: <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 FREE!
As the legal parent/guardian, I hereby consent to the release and sharing 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." Privacy Practices are available on the All Smiles Community Oral Health website AllSmilesCOH.org/forms .	
Parent/Guardian Signature: _____ Date: _____	

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The confidentiality of your protected health information, also called your medical record, is a high priority at All Smiles Community Oral Health. There are a number of reasons we may need to use this information or disclose it to others. This Notice of Privacy Practices is provided to inform you of the ways we can use and release information from your medical record. THIS PAGE IS NOT THE FULL NOTICE OF PRIVACY PRACTICES. The full notice is available upon request. In addition to our longstanding commitment to protecting your information, there are certain obligations we have under federal law. One of those obligations is to provide you with this Notice.

THINGS EXPLAINED IN THE FULL NOTICE OF PRIVACY PRACTICES

- **How we may use and share your health information without your permission to:**
 - Provide treatment to you.
 - Get paid for the services we provide to you.
 - Make reports to federal, state, and local agencies and others when the law requires such reporting.
 - Make reports or share information for public health, safety, and/or research purposes.

- **How we can share your information without your permission, but only if we give you a chance to object:**
 - To share information about you to family, friends, or others involved in your care for payment for the services you receive.
 - To share information in case of a disaster to let your family and friends know where you are and your general condition.

- **How we can use and share your medical information only with your permission for disclosures other than those described above.**

- **Your legal rights under federal privacy laws include your right to:**
 - Ask to see and copy your medical information.
 - Ask that incorrect or incomplete information in your medical information be corrected.
 - Ask for a list of the places we have sent your information unless it was sent with your permission, for payment, treatment, or health care operations.
 - Ask that we limit the information we use or share for treatment, payment, or healthcare operations, or the information we share with family members or others involved in your care. We are not required to agree to your request.
 - Ask that we communicate with you in a confidential manner.
 - Ask for a paper copy of the Notice of Privacy Practices at any time.
 - Be notified in the event of a breach of unsecured, protected health information.
 - File a complaint if you think your privacy rights have been violated.
 - Pay out of pocket in full for a healthcare item or service and restrict disclosure of that particular item or service to your health plan provider.