Indigenous Services Canada | Services aux Autochtones Canada

PROTECTED **B** (when completed)

CHILDREN'S ORAL HEALTH INITIATIVE (COHI) AUTHORIZATION

Privacy statement

The collection, use and disclosure of personal information by the Community Oral Health Services is authorized under the *Department of Indigenous Services Act* (https://laws-lois.justice.gc.ca/eng/acts/I-7.88/index.html) and is in accordance with the *Privacy Act* (https://laws-lois.justice.gc.ca/eng/acts/P-21/index.html). Information collected will be used exclusively for the prevention of dental disease and promotion of good oral health practices as well as delivering dental therapy services, including diagnosis, prevention, treatment and follow-up. Personal information will be retained pursuant to the *Privacy Act* and its Regulations. The information collected is described in the HC PPU 008 and HC PPU 009 located in the departmental Info Source (https://www.aadnc-aandc.gc.ca/eng/1353081939455/1353082011520) publication. Individuals have the right to the protection of, access to and to request the correction of their personal information under the *Privacy Act*. If you require clarification concerning the Privacy Statement, please contact the Departmental Access to Information and Privacy Office at 1-819-997-8277 or by email at aadnc.upvp-ppu.aandc@canada.ca. For more information on privacy issues, your right to file a complaint and the *Privacy Act* in general, you can consult the Privacy Commissioner at 1-800-282-1376.

► **To be completed by parent, guardian or authorized representative** (please use block letters)

Child's legal family name	Given name

Grade	Gender	Date of birth (YYYYMMDD)	Registration/Treaty or 'N' number (9 or 10 digit number)
	◯ Male ◯ Female ◯ Other		

Child's health history

Does the child have any of the following?	Yes	No	Unknown
Heart problems	◯	◯	◯
Diabetes	◯	◯	◯
Bleeding problems	◯	◯	◯
Allergies (if yes, explain)	◯	◯	◯
Other health conditions (if yes, explain)	◯	◯	◯
Dental work previously done under General Anesthetics (GA) in the past year?	◯	◯	◯
Child takes fluoride supplements (i.e. drops or tablets)?	◯	◯	◯

By signing below I,

(a) Give my authorization for child (named above) to receive any of the following oral health services:

- Dental screening
- Fluoride varnish applications
- Dental sealant applications (if required)
- ART or IST (temporary painless filling if required)
- Oral health information sessions

► Complications or reactions to these procedures are unusual. However, if the child has any complications or reactions to these services, please contact a nurse or oral health professional.

(b) Give my authorization for The Government of Canada to collect, use and disclose information about the child for the purposes of the Children's Oral Health Initiative;

(c) Give my authorization for The Government of Canada to access the child's pandemic/epidemic screening results, obtained by partner organizations, for the purposes of meeting Dental Regulatory Authorities & Provincial/Territorial Associations' screening criteria, pursuant to section 4 of the *Privacy Act*;

(d) Understand that the personal information of the child is protected under the *Privacy Act* and the information may only be used or disclosed within the conditions set out in the *Privacy Act*;

(e) Understand that oral health program records and data information may be used by the Government of Canada, for management and administration purposes only directly related to the Children's Oral Health Initiative;

(f) Confirm that I have read and understand the content of this authorization form;

(g) Choose to give my consent voluntarily;

(h) Understand that this consent will remain in effect until it is withdrawn in writing by a parent, guardian or authorized representative of the above-named child.

Parent/Guardian/Authorized Representative

Family name	Given name	Telephone number

Signature	Date (YYYYMMDD)

Canada