

COHI PROGRAM INFORMATION



PARENT/GUARDIAN;

Interlake Reserves Tribal Council's Children's Oral Health Initiative (COHI) offers free, preventative, oral health services to children in your community.

These services are free of charge and are in addition to your oral health Non-insured Health Benefits.

Benefits of participating in COHI:

- A gentle and easy way to introduce children to oral health
- Services provided by COHI help reduce tooth decay (i.e., cavities)
- You and your child learn good oral health habits that are important to your family's overall health

Who provides COHI services?

COHI services are provided by Skylar Procillo - Tribal Dental Hygienist and Andi Bayer – Dental worker Aide.

Services We Provide

Oral Screening

- A visual oral exam

Fluoride Varnish

- Applications 2-3 times per year to help prevent or slow down cavities

Referrals

- To a community dentist if applicable or for dental surgery

Sealants

- Help prevent cavities in pits & grooves of new adult molars

Temporary Fillings (IST)

- Help prevent the growth of existing cavities

Oral Health Education

- Classroom, 1-on-1 & group presentations

Silver Diamine Fluoride (SDF)

- Helps stop/slow early cavities

SILVER DIAMINE FLUORIDE (SDF) TREATMENT INFORMATION

Silver Diamine Fluoride (SDF)

- A liquid treatment option for tooth decay (cavity)
- SDF requires 2-3 applications for optimal results
- Safe and approved by Health Canada to stop the cavity from progressing

Benefits of receiving SDF:

- Prevents cavities from growing
- Pain free
- No needles or drilling

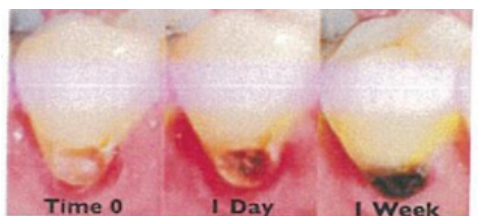
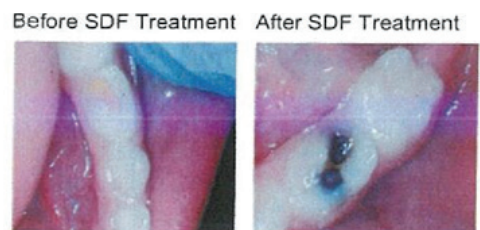
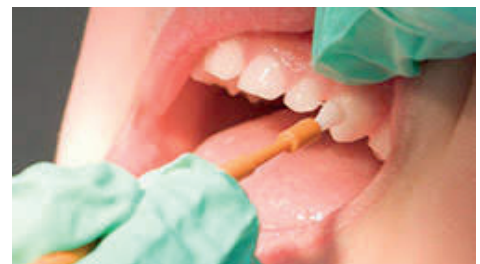
Risks of receiving SDF:

- **The cavity** will stain black permanently
- If accidentally applied to the skin or gums, the stain will disappear in 1-4 weeks
- After SDF treatment, a filling or crown may still be needed
- SDF is not ideal for large painful cavities

Risks if not treated:

- Infection
- Pain
- Dental surgery

A person should **NOT** be treated with SDF if they are **allergic to silver** or there are painful sores or raw areas in their mouth





COMMUNITY ORAL HEALTH SERVICES (COHS) AUTHORIZATION

Privacy statement

The collection, use and disclosure of personal information as a part of Indigenous Services Canada's (ISC) Community Oral Health Services program is authorized under Section 6 of the [Department of Indigenous Services Act](https://laws.justice.gc.ca/eng/acts/i-7.88/page-1.html) (https://laws.justice.gc.ca/eng/acts/i-7.88/page-1.html), and is in accordance with the requirements of [Privacy Act](https://laws-lois.justice.gc.ca/eng/acts/P-21/index.html) (https://laws-lois.justice.gc.ca/eng/acts/P-21/index.html). Information collected will be used exclusively as documentation for client treatment, as well as for program reporting and evaluation. The collection, use and disclosure of your personal information is required for your participation in the Program. Personal information will be retained pursuant to the *Privacy Act* and its *Regulations*. The collection of information is described in the departmental Personal Information Bank for Community Oral Health Services (PPU 008) available online at <https://www.sac-isc.gc.ca/eng/1639748667069/1639748703555#chp06>. Individuals have the right to the protection of, access to and request the correction of their personal information under the *Privacy Act*. If you require clarification concerning the Privacy Notice Statement, please contact the Departmental Access to Information and Privacy Office at 1-819-997-8277 or by email at upvp-ppu@sac-isc.gc.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 if the client is a minor** (use block letters)

Client's legal family name		Given name		Date of birth (YYYYMMDD)
Sex at birth <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Other	Gender identity	Gender pronouns	Registration/Treaty or 'N' number (9 or 10 digit number)	
Address (Number / street / apartment / P.O. box, city or town, province/territory, postal code)			Community	

By signing below I,

(a) Give my authorization for client (named above) to receive any of the following oral health services (*select below*):

- | | |
|---|---|
| <input type="checkbox"/> Oral screening | <input type="checkbox"/> Fluoride varnish applications |
| <input type="checkbox"/> Oral health information sessions | <input type="checkbox"/> Temporary fillings ART or IST (if required) |
| <input type="checkbox"/> Dental sealant applications (if required) | <input type="checkbox"/> Silver diamine fluoride (if required) |

► Complications or reactions to these procedures are unusual. However, if the client 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 client for the purposes of the Community Oral Health Services;

(c) Give my authorization for The Government of Canada to access the client'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 client 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 Community Oral Health Services;

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

(g) Choose to give my consent voluntarily; and

(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 client.

► **Consenting person's information** if the client is a minor (parent, guardian, substitute decision maker, person having a legally recognized authority to act on behalf of the client).

Given name	Family name	Telephone number
Relationship to client	Community	
Address (Number / street / apartment / P.O. box, city or town, province/territory, postal code)		

► **Client authorization**

Signature	Date (YYYYMMDD)
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COHI PROGRAM CONSENT FORM



MEDICAL HISTORY

1.) Has this child ever been hospitalized or required extensive medical care?

 NO YES

If YES, please explain:

2.) Is the child currently under a doctor's care?

 NO YES

If YES, please explain:

3.) Is the child currently taking any medication or drugs of any kind?

 NO YES

If YES, please explain:

4.) Does the child have any allergies? food, medication, aspirin, penicillin, sulfonamide, local anesthetic (freezing), latex rubber, metals or jewelry (**especially silver**)

 NO YES

If YES, please explain:

5.) Does the child have, or in the past had any of the following conditions? (check all that apply)

 NONE HEART DISEASE/DEFECT EPILEPSY OR SEIZURES LIVER DISEASE RHEUMATIC FEVER KIDNEY DISEASE HEART MURMUR ASTHMA OR HAY FEVER TUBERCULOSIS SCARLET FEVER HEPATITIS BLOOD/BLEEDING PROBLEMS DIABETES CANCER MENTAL HEALTH PROBLEMS AIDS OTHER, PLEASE EXPLAIN:

CHILD MEDIA/PHOTO RELEASE FORM

I, HEREBY GRANT GRANT SKYLAR PROCILLO RDH & ANDI BAYER OF THE IRTC-COHI PROGRAM MY PERMISSION TO USE PHOTOGRAPHS OF MY CHILD AND/OR THEIR TEETH FOR ANY PROFESSIONAL USE, INCLUDING BUT NOT LIMITED TO: PUBLICITY, ILLUSTRATION AND ADVERTISING.

*FURTHERMORE, I UNDERSTAND THAT NO ROYALTY, FEE, OR OTHER COMPENSATION SHALL BECOME PAYABLE TO ME BY REASON OF SUCH USE.

SIGNATURE: