Dental history

Please list any concerns you may have that your child has with his/her teeth or mouth:

Is your child receiving treatment from another dentist? ☐ Yes ☐ No

If yes, details:

Is your child attending an orthodontist/dental specialist? ☐ Yes ☐ No

If yes, details:

Do you believe your child is of Aboriginal or Torres Strait Islander descent, or is your child of South Sea Islander origin? *(please tick one box)*

☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ South Sea Islander

In which country was your child born? *(please tick one box, and enter name of country if born overseas)*

☐ Australia ☐ Another country: Name:

What language is spoken at home?

Do you require an interpreter? ☐ Yes ☐ No

If yes, details:

Signed: *parent / guardian* / /

Office use only (checked by operator):

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

Toowoomba Oral Health Service
Phone: 4616 6436

Queensland Government

Parental Consent and Medical/Dental History

The School Dental Service offers free dental treatment to students enrolled from Prep to Year 10. A qualified and skilled team of dental professionals work together to deliver a range of preventive and general dental treatment.

Details of your child:

Last Name:

Given names:

Date of birth: / / Gender: ☐ Male ☐ Female

Home address:

State: Postcode:

Postal address *(if different)*:

State: Postcode:

Ph (H): Ph (M): Fax:

Email:

Contact person in case of emergency: Ph (H): Ph (M):

School attended:

Grade:

Medicare number: Card ID: Valid to: /

Health Care card number *(if applicable)*: Expiry date: / /

I *print name / guardian name* ☐ **do** ☐ **do not** **give consent** to a representative of the Department of Health contacting me regarding oral health services via the contact details I have provided. This includes texting to the mobile phone number provided.

Signed: *parent / guardian* / /

What is your relationship to this child?

v2.00 - 04/2015

Consent to examination and preventive oral care *(tick one box only)*

1. I consent to my child receiving the following:
   - a dental examination
   - dental xrays, if considered necessary as part of the examination
   - preventive oral care if considered necessary, such as oral health education, cleaning of teeth, and the application of fluoride to the teeth.

   I understand that the examination (and any associated procedure which is considered necessary) may involve more than one visit to the school dental clinic.

   I also understand that if I consent to the above, a separate consent form will be issued to me should any further treatment be recommended.

   ☐ **Yes, I consent** ☐ **No, I do not consent**

2. I consent to other health professionals being consulted where it will assist in the provision of my child's oral health care.

   ☐ **Yes, I consent** ☐ **No, I do not consent**

3. I consent to health professionals who have treated my child exchanging such information about my child as may be required to assist in providing oral health care to my child. I also consent to information that has been collected by the Department of Health, when providing oral health care to my child, being used by the Department of Health to check and assess the oral health services my child has received and how those services have been used, so long as my child's name is not used in any reports or published statistics.

   ☐ **Yes, I consent** ☐ **No, I do not consent**

Signed: *parent / guardian* / /

Your name *(print)*:

Medical history

I have confidential medical information about my child that I do not wish to write down. I would prefer to speak to a dentist about this.

☐ Yes *(If relevant to the child's dental treatment, this information will be recorded in the child's dental record)*

☐ No

Who is your child's usual doctor?

Name:

Address: Phone:

Is your child being treated by a doctor at present? ☐ Yes ☐ No

If yes, details:

DO NOT WRITE IN THIS BINDING MARGIN

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Does your child have, or has your child ever had, any of the following medical conditions? *(please tick appropriate box)*

	Y	N		Y	N
Rheumatic fever			Steroid therapy		
Heart complaint			Contact with HIV/AIDS virus		
Heart valve disorder, e.g. murmur			Cystic fibrosis		
Cardiac pacemaker			Asthma/bronchitis		
Prosthetic or other implant, e.g. shunt			Tuberculosis		
Leukaemia			Stomach or digestive condition		
Anaemia			Diabetes		
High or low blood pressure			Kidney disease		
Bleeding disorders, e.g. von Willebrands, haemophilia			Hepatitis or other liver disease		
Stroke			Autism Spectrum		
Thyroid disease			Epilepsy		
Growth disorder			Radiation therapy		

Details:

Is your child allergic to any drugs or medication?	Y	N
If yes, details:		
Has your child any known allergies (including latex)?	Y	N
If yes, details:		
Is your child taking any tablets or medicines (prescribed or over-the-counter) at present?	Y	N
If yes, details:		
Does your child have any abnormal reactions to local or general anaesthesia?	Y	N
If yes, details:		
Does your child normally require antibiotic cover before dental treatment?	Y	N
If yes, details:		
Does your child smoke?	Y	N
Is your child pregnant?	Y	N