Queensland Government

ORAL HEALTH SERVICES

PARENTAL CONSENT and MEDICAL / DENTAL HISTORY FORM

Please complete this form and return it to the school or dental clinic by:

(Late returns will be accepted however treatment may be offered at a different location.)

DETAILS OF YOUR CHILD

Last name: Date of birth:

First name(s): Gender Male / Female

Home address:

Postal address (if different):

Emergency contact: Phone:

School attended: Grade:

CONSENT TO EXAMINATION AND PREVENTIVE CARE

I consent to my child receiving the following: (Tick one box only) Yes / No

- a dental examination, and
- dental x-rays, if considered necessary as part of the examination, and
- preventive care if considered necessary such as oral hygiene instruction, cleaning of teeth and the application of fluoride.

I understand the examination and any associated procedure which is considered necessary may involve more that one visit.

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

Signed *(Parent / Guardian):*

Your name *(please print):*

Your address *(if different from above):*

Date:

Contact telephone *(Home):* *(Work):*

(Email): *(Mobile):*

I consent to receiving contact from the Oral Health Service by SMS and/or email.

Yes / No (Tick one box only)

IF YOU HAVE TICKED "YES" TO YOUR CHILD RECEIVING A DENTAL EXAMINATION AND PREVENTIVE CARE, PLEASE COMPLETE THE QUESTIONNAIRE OVERLEAF

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PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS

DENTAL HISTORY

	Yes	No
Has your child been treated previously at a school dental clinic in Queensland? If **YES**, please give the name of the school where your child was last treated, and the year when he or she left:		
School: ***Year:***		
Is your child available for treatment before or after school? If **YES**, please indicated the available times:		
Is your child receiving treatment from another dentist? If **YES**, please give details:		
Is your child attending an orthodontist/dental specialist? If **YES**, please give details:		
Please list any problems your child has with his/her teeth or mouth:		

MEDICAL HISTORY

I have confidential medical information about my child that I wish to speak to a dentist about (please tick if appropriate).	

DOES HE / SHE HAVE, OR HAS HE / SHE EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS? (Please tick)

	Yes	No		Yes	No
Rheumatic fever			Contact with HIV / AIDS virus		
Heart complaint			Epilepsy		
Heart valve disorder e.g. murmur			Radiation therapy		
Cardiac pacemaker			Steroid therapy		
Prosthetic or other implant e.g. shunt			Asthma		
Anaemia, leukaemia or other blood diseases			Bronchitis or other lung diseases		
Excessive bleeding			Tuberculosis		
High or low blood pressure			Stomach or digestive condition		
Stroke			Diabetes		
Thyroid disease			Kidney disease		
Growth disorder			Hepatitis or other liver disease		
Nervous condition e.g. ADD			Any other condition(s) (Please list below)		

Other condition(s) not listed above:

	Yes	No
Is your child being treated by a doctor at present? If **YES**, please give details:		
Is your child taking any tablets or medicines (prescribed or over-the-counter) at present? If **YES**, please give details:		
Does your child normally require antibiotic cover before dental treatment? If **YES**, please give details:		
Does your child have any abnormal reactions to local or general anaesthesia? If **YES**, please give details:		
Does your child smoke?		
Is your child pregnant? (females only)		

Please list any drugs or medicines your child is allergic to:

Please list any other known allergies that your child has e.g. latex:

Who is your child's usual doctor?

Name: Phone:

Address:

Is your child of Aboriginal or Torres Strait Islander or South Sea Islander origin? (please tick)

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 of country: .....

What language is spoken at home? .....

I consent to other health professionals being consulted where it will assist in the provision of my child's oral health care, and to information relating to my child's oral health care being used by Queensland Health for evaluation purposes so long as my child's name is not used in any reports or published statistics.

Signed *(Parent / Guardian)*:

Date: / /

Office use only: (Checked by dental practitioner)