Queensland Government
Queensland Health

ORAL HEALTH SERVICES

PARENTAL CONSENT and MEDICAL / DENTAL HISTORY FORM

Please complete all the details about your child and return this form to the school or school dental clinic by: (Late replies will be accepted but treatment may be offered at another facility/location)	

DETAILS OF YOUR CHILD

Last name:	Title *(eg Mr/Mrs/Ms)*:
First name(s):	Date of birth:
Home address:	Gender Male / Female
	Phone (Home):
	Phone (Work):
Postal address (if different):	
Contact person in case of emergency:	
	Phone:
School attended:	Grade:

CONSENT TO EXAMINATION AND PREVENTIVE ORAL CARE

(Tick one box only)

Yes	No

I consent to my child receiving the following:

- a dental examination, and
- dental x-rays, if considered necessary as part of the examination, and
- preventive oral care if considered necessary such as oral hygiene assistance, 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 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)*

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

REV: MARCH 2002

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 indicate the available times:	Yes	No
Is your child receiving treatment from another dentist? If **YES**, please give details.	Yes	No
Is your child attending an orthodontist/dental specialist? If **YES**, please give details.	Yes	No

Please list any problems that your child has with his/her teeth or mouth:

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 *(please tick box).*	

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

	Yes	No		Yes	No
Rheumatic fever			Contact with HIV/AIDS virus		
Heart complaint			Epilepsy		
Heart valve disorder, eg murmur			Radiation therapy		
Cardiac pacemaker			Steroid therapy		
Prosthetic or other implant, eg 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, eg 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	Yes	No
Does your child normally require antibiotic cover before dental treatment? If **YES**, please give details	Yes	No
Does your child have any abnormal reactions to local or general anaesthesia? If **YES**, please give details	Yes	No
Does your child smoke?	Yes	No
Is your child pregnant? *(Females only)*	Yes	No

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

Please list any other known allergies that your child has (including latex)

Who is your child's usual medical practitioner?

Name Phone

Address

Is your child of Torres Strait Islander or 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 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 operator)