Queensland Government

Central Queensland Hospital and Health Service

ORAL HEALTH PARENTAL CONSENT & MEDICAL/DENTAL HISTORY

Facility / Unit: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Phone:

Date of birth: Sex: ☐ M ☐ F ☐ I

PLEASE COMPLETE THESE FORMS USING BLACK PEN ONLY

Details of your child

Last Name:		Given Names:	
Has your child ever been known by another name?	☐ Yes ☐ No *If Yes, please write name:*		
DOB:		Gender:	*circle one* Male Female
Home Address:			
Postal Address:			
Parent / Guardian Name: *(please print)*		Phone (mobile): ***Are you willing to receive SMS appointment reminders?*** ☐ Yes ☐ No	
Relationship to child:		Phone (home): Phone (work):	
Child's Doctor	Name: Phone:	Emergency Contact:	

Medicare Number											Ref. Number			Expiry Date: /

School: Grade:

Consent to Examination and Preventative Oral Care

I consent to my child receiving the following:

- A dental examination including and if considered necessary, dental x-rays and/or preventive oral care - 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, in this instance, a separate consent form will be provided should any further treatment be recommended.

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 Queensland Health, to be used 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 public statistics.

Help us connect with you!

Does your child identify as:
(Please tick box if applicable)

☐ Aboriginal ☐ Torres Strait Islander

☐ South Sea Islander ☐ None of the above

In which country was this child born? *(please tick ONE box)*

☐ Another country: _____ ☐ Australia

Do you require an interpreter?

☐ Yes
☐ No

Is this child in the custody of Dept. of Child Safety?

☐ Yes *(give details)*
☐ No

Please sign if you consent to the Examination and Preventative Oral Care as outline above:

Signature:
Parent / Guardian

Date:

Please go to page 2 and complete and sign the Medical History section.

DO NOT WRITE IN THIS BINDING MARGIN

Do not reproduce by photocopying
All clinical forms creation and amendments must be conducted through Health Information Unit

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PARENTAL CONSENT & MEDICAL / DENTAL HISTORY

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ORAL HEALTH SERVICES
Central Queensland Hospital and Health Service

PARENTAL CONSENT & MEDICAL/DENTAL HISTORY

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URN:

Family name:

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Medical History

Child's Name: DOB:

What is your child's weight?

Does this child has, or ever had, any of the following medical conditions?

	Yes	No		Yes	No		Yes	No
Sensory condition			Hepatitis or other liver disease			Bronchitis or other lung diseases		
Attention Deficit Disorder (ADD)			Stroke			Tuberculosis		
Autism			Contact with HIV/AIDS			Stomach or digestive condition		
Heart Complaint			Growth Disorder			Rheumatic Fever		
Prosthetic or other implant			Epilepsy			Diabetes		
Thyroid Disease			Radiation Therapy			Kidney Disease		
Excessive bleeding			Steroid Therapy			Asthma		
Anaemia, leukaemia or other blood diseases			High or low blood pressure			Any other condition(s) *please list below*		

Other condition(s) / special needs not listed above that will assist us in providing appropriate oral health care for your child:

Please tick Yes or No for the following:	Yes	No	Details
Does your child have a disability?			
Is your child being treated by a doctor at present?			
Is your child taking any tablets or medicines (prescribed or over-the-counter) at present?			
Does your child normally require antibiotic cover before dental treatment?			
Does your child have any abnormal reactions to local or general anaesthesia?			
Does your child smoke?			
Is your child pregnant?			
Do you or your child require wheelchair access?			

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

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

Dental History

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

Signed (Parent/ Guardian):		**Date**:		**Signed** (Clinician):	