Queensland Government

Child Oral Health Consent and Medical History

URN:
Family Name:
Given Names:
Address:
Date of Birth:
M ☐ F ☐ I ☐
Telephone:

For Admin Use Only

Child Oral Health Consent

DETAILS OF YOUR CHILD:

Last Name: First name:
Preferred name: Date of birth: Sex ☐ M ☐ F ☐ I

Home Address:

Street Number and Name: Suburb: Postcode:
Postal address: *(if different to above)* Email:
Name of Contact 1: Phone Contact:
Name of Contact 2: Phone Contact:
School Attended: Grade:

I consent to being contacted by the Oral Health Service by SMS and/or email. ☐ Yes ☐ No

Is your child of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander

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

☐ Australia ☐ Another country Name of the country:

What language is spoken at home: Do you require an interpreter? ☐ Yes ☐ No

Is this child in the custody of the Department of Child Safety: ☐ Yes ☐ No

If YES, Department of Child Safety branch details:
Phone: Email:

Medicare and/or Healthcare/Concession card details:

Medicare number: Reference number: Expiry: /
Concession/Healthcare card number: Expiry: /
Is your child eligible for the Medicare Child Dental Benefit Schedule? ☐ Yes ☐ No ☐ Unsure

NEXT OF KIN DETAILS:

Last Name: First name:
Relationship to child: Contact Phone:
Street Number and Name: Suburb: Postcode:

DOCTOR'S DETAILS:

Practice Name: Doctor's name:
Address: Contact Phone:

CONSENT TO EXAMINATION AND PREVENTIVE CARE

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 care if considered necessary such as oral hygiene instruction, cleaning of teeth and the application of fluoride.

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

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

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

Parent / Guardian name:

Signature: _____ Date:

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DENTAL HISTORY INFORMATION:

Has your child been treated previously at a school dental facility in Queensland? ☐ Yes ☐ No

Is your child receiving treatment from another dentist or dental specialist e.g. orthodontist? ☐ Yes ☐ No

If **Yes**, please provide details:

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

MEDICAL HISTORY INFORMATION:

Does your child have, or have they ever had, any of the following medical conditions?

☐ I have confidential medical information about my child that I do not wish to write down. I would prefer to speak to the oral health professional about this. *(Please tick if appropriate)*

Please tick **YES** or **NO** for each medical condition listed:

Is your child taking any tablets, medication or inhalers (prescribed or over the counter)? ☐ Yes ☐ No

If **Yes**, please provide details:

Does your child have any known allergies e.g. latex, penicillin, anaesthetic? ☐ Yes ☐ No

If **Yes**, please provide details:

Any previous hospitalisations or operations under general anaesthetic? ☐ Yes ☐ No

If **Yes**, please provide details:

Does your child require antibiotic cover before dental treatment? ☐ Yes ☐ No

If **Yes**, please provide details:

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Smoking / tobacco use	☐	☐	Heart valve disorder or replacement e.g. heart murmur	☐	☐	Stomach or digestive condition	☐	☐
Mental health condition	☐	☐	High or low blood pressure	☐	☐	Renal (kidney) disease	☐	☐
Disability	☐	☐	Respiratory (lung) condition e.g. Bronchitis	☐	☐	Bleeding disorder	☐	☐
Sensory / Auditory processing disorder	☐	☐	Asthma	☐	☐	Hepatitis	☐	☐
Attention Deficit Hyperactivity Disorder (ADHD)	☐	☐	Epilepsy	☐	☐	Chemotherapy / Radiation therapy	☐	☐
Autism Spectrum Disorder (ASD)	☐	☐	Syndrome / Developmental condition	☐	☐	Pregnancy	☐	☐
Cardiovascular (heart) condition	☐	☐	Diabetes	☐	☐	Other	☐	☐

Please list any other conditions or information:

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.

Signature of Parent / Guardian: _____ Date:

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