Capital Dental Mobile Clinic Enrolment for Adolescent Oral Health Services

Do you provide consent for your child _____to receive FREE basic Dental Care and Dental Health at Capital Dental Mobile Clinic? ☐Yes ☐No
If yes, kindly fill out the form below and send it back to Upper Hutt College reception.

Medical History (Confidential)

This document provides the information your clinician needs for your child's dental treatment and oral health care.

Last Name:_____

First Names:_____

Date of Birth:_____ **School Name:**_____

Parents/Guardian Contact Details: (Home)_____

(Work)_____**(Mobile)** _____

Address:_____

Family Doctor:_____ **Name of Medical Practice:**_____

In order to provide the best and safest dental treatment, our clinician needs to know of any medical problems which may affect your child's treatment. Have you ever had any of the following?

Heart Problems	☐Yes	☐No	Sinus/Hay Fever	☐Yes	☐No
Rheumatic Fever	☐Yes	☐No	Epilepsy	☐Yes	☐No
Surgery	☐Yes	☐No	Diabetes	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	Kidney Problems	☐Yes	☐No
Stroke (Blood Clot)	☐Yes	☐No	Gastric Problems	☐Yes	☐No
Asthma	☐Yes	☐No	Depressive Illness	☐Yes	☐No
Chest & Lung Disease	☐Yes	☐No	Cancer	☐Yes	☐No
Other, please list:					

Is your child taking any tablets, medicines, pills or drugs? If yes, please list.

_____

Does your child have you ever had any allergies to medicines, or other substances (such as Latex)? If so, please list.

_____

Has your child ever been admitted to hospital? If so, please list reason.

_____

Has your child ever had contact with HIV, Hepatitis B or Hepatitis C? ☐Yes☐No

Has your child ever had an unfavourable reaction to dental injection?☐Yes☐No

Are there any other health matters you need to inform the dental clinician? If so, please list.

_____

I confirm that the information written above is true and correct to the best of my knowledge, and I consent for my child to receive FREE Basic Dental Care and Dental Health as provided by Capital Dental

Patient/Parent/Guardian Signature_____

Date_____