Queensland Government

Central Queensland Hospital and Health Service

Child/Adolescent Consent and Medical/Dental History Form

Facility / Unit: Oral Health Services

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Phone:

Date of birth: Sex: ☐ M ☐ F ☐ I

Thank you for taking the time to complete this form. It is important to know details about your child's medical history to ensure we can provide the best care. **Please tick ALL the boxes *Yes* or *No***

Patient Personal Details		
Last Name:	Title *e.g. Mr/Miss*	Date of Birth:
Given Name(s):	Gender: Male ☐ Female ☐ Indeterminate ☐	
Has your child ever been known by another name? Yes ☐ No ☐ If yes please state other names:		
Home Address:		
Mailing Address:		
Is your child of Aboriginal, Torres Strait Islander or South Sea Islander origin: No ☐ Aboriginal ☐ Torres Strait Islander ☐ South Sea Islander ☐		
In which country was your child born: Australia ☐ Another country ☐ (please state):		
Language spoken:	Do you require an interpreter: Yes ☐ No ☐	
Medicare Card	Reference	Expiry: /
School: CALLIOPE STATE SCHOOL Grade:	Boarder: Yes ☐ No ☐	
Is this child in the custody of Department of Child Safety? Yes ☐ No ☐ If yes please provide details: Contact Person:	Phone:	
Parent/Legal Guardian's Details		
Parent/Legal Guardian Name:	Relationship to child:	
Phone (home):	Phone (work):	
Phone (mobile):	Email:	
I consent to receiving contact from Oral Health Services by SMS and/or email: Yes ☐ No ☐		
Emergency Contact Details (if different to above)		
Emergency Contact Name:	Relationship to child: Phone:	
Patient's General Practitioner Details		
GP Practice Name:	GP Name:	
GP Address:	GP Phone:	

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

- A separate consent form will be provided should any further treatment be recommended.
- My child may be collected from class to attend appointments.

Please sign this section if you consent to the Examination and Preventative Oral Care as outlined above:

Parent/Legal Guardian Signature_____ **Date**_____

PLEASE TURN OVER

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Patient Medical Details

Current Weight (kg):

Allergies **Yes** ☐ **No** ☐
PLEASE WRITE DOWN all allergies, including allergies to medications

Medications **Yes** ☐ **No** ☐
PLEASE WRITE DOWN all tablets, vitamins, regular injections, inhalers and any other medications including natural remedies *(You can bring a printed list from your doctor or pharmacy)*

Please tick ***Yes*** or ***No*** to the following conditions

	Yes	No
Have you been advised that your child requires **Antibiotic prophylaxis before** dental treatment? e.g. for a heart condition.	☐	☐
Previous operation under **General Anaesthetic**	☐	☐
Previous anaesthetic complications	☐	☐
Smoking	☐	☐
Pregnancy (Females only)	☐	☐
Alcohol	☐	☐
Recreational drugs	☐	☐
Mental health e.g. Depression, anxiety, etc *Please specify:*	☐	☐
Disability e.g. Intellectual, sensory, physical, etc *Please specify:*	☐	☐
Developmental/Neurological e.g. ADHD, Autism, etc. *Please specify:*	☐	☐
Blood pressure: ***High / Low***	☐	☐
Heart conditions/operations e.g. Stent, valves, heart attack, etc *Please specify:*	☐	☐
Rheumatic Heart Disease	☐	☐
Lung condition e.g. Asthma, COPD, etc	☐	☐
Nervous system e.g. Epilepsy, MS, Stroke etc	☐	☐
Developmental Condition e.g. Downs Syndrome	☐	☐

	Yes	No
Diabetes: ***Type 1 / Type 2*** *Please specify Blood Sugar Level:*	☐	☐
Thyroid	☐	☐
Hormone problems	☐	☐
Digestive problems e.g. Reflux, ulcer, etc	☐	☐
Kidney disease e.g. Dialysis, etc	☐	☐
Blood disorders e.g. Haemophilia, etc	☐	☐
Liver disease e.g. Hepatitis, fatty liver, etc	☐	☐
Immune System Problems	☐	☐
Blood Borne Viruses e.g. Hep B, Hep C, HIV, etc	☐	☐
Osteoarthritis or Rheumatoid Arthritis	☐	☐
Osteoporosis	☐	☐
Prosthetic joint(s) e.g. Knee Replacements, etc	☐	☐
Cancer (past or present) *Please specify:*	☐	☐
Has your child had **Chemotherapy**? *If yes, when:*	☐	☐
Has your child had **Radiotherapy**? *If yes, when and which part of body:*	☐	☐
Other Medical Conditions, Additional Information *or* **Dental Concerns:**		

Privacy Statement

Personal Information collected by Queensland Health from patients is handled in accordance with the *Information Privacy Act 2009* and the *Hospital and Health Boards Act 2011*. Your Personal Information is being collected by way of this form to provide you with oral health services. The Personal Information provided by you will be securely stored and made available to appropriately authorised staff of Queensland Health.

Your personal information may also be disclosed to health practitioners who have in the past or will provide you with care or treatment, to staff of Queensland Health for the purpose of conducting assessment of the services provided to you or otherwise for the purpose relating to providing you with public sector health services. Personal information recorded on this form will not be used or disclosed to other parties without your consent, unless authorised or required by law.

For information about how Queensland Health protects your personal information, or to learn about your right to access your own personal information, please see our website at **www.health.qld.gov.au**.

Parent/Legal Guardian Signature_____ **Date**_____