Please tick if your child has had any of the following:

	Yes	No
Respiratory disease e.g. asthma, lung disease, TB, persistent cough, bronchitis		
Heart condition or heart murmur, Congenital heart defect		
Heart surgery e.g. Artificial heart valve, pacemaker		
Rheumatic fever		
Low or high blood pressure		
Treatment for cancer (Chemotherapy or radiotherapy)		
Excessive bleeding or blood disorder		
Other surgery e.g. transplant, artificial joint		
Injury to head, neck or spine		
Seizures or epilepsy		
Chronic medical condition E.g. Stroke, arthritis		
Diabetes What type?_________________		
Kidney disease		
Liver disease, Hepatitis		

Tick if applicable:

Is the child pregnant or could be pregnant?		
Does your child use tobacco products(smoking)?		
Does your child use e-cigarette (vaping)?		
Does your child drink alcohol?		

CONSENT FORM

Preventive Oral Health Programs

Oral Health Services- Ministry of Health

Only parents, legal guardians may complete and sign this consent form to provide consent for examination and other oral preventive services.

I **give / do not give consent** for (*Child name*) :_______________________________
to participate in the Preventive Oral Health Program .

He/ She can receive the following preventive services at his/her school, during class hours and during my absence.

**Tick as appropriate* Dental examination (check up) Yes ☐ No ☐

	Yes	No
X-Ray of teeth		
Fissure sealants:		
Tooth cleaning:		
*Fluoride varnish:		

You must say yes to a dental check up before any other services can be provided.

** Varnish may not be suitable if your child has an allergy to the items mentioned earlier or severe asthma.*

I, (parent/guardian name)____

agree that I have to the best of my knowledge provided all the relevant health and personal information that is required to provide appropriate preventive care .

In giving consent, I agree that I have read this consent form and the information sheet. I have enough information to understand the types of preventive dental services offered including the benefits and risks involved, where the service will take place and who will be providing them.

Parent/.guardian signature:

Date ____/______/________

This consent form is valid for 12 months from the date it is signed.
It shall be renewed and updated yearly. However ,if there be any change in the medical history, please inform your Dental Therapist/Dental Hygienist.

STUDENT DETAILS

PLEASE COMPLETE FORMS IN BLOCK CAPITALS

School name: ________________________________Class: ________Year: ________

First name:____

Other names:____

Surname:____

Sex: Male ☐ Female ☐ Date of birth:________/_________/_________

NIN: ☐☐☐ ☐☐☐☐ ☐ ☐ ☐☐

Address:____

PARENT/ GUARDIAN DETAILS

First name:______________________________Surname:______________________

NIN:

Relationship to child:____

Tel: 1.____________________________2.___________________________________

ORAL HEALTH QUESTIONNAIRE

Has your child had his/her teeth checked before?

Yes ☐ ☐ No

If yes, state which dental clinic he/she visited last:

*Clinic*____

Is your child currently under the care of a dental specialist

(Orthodontist/ paedodontist) ? Yes ☐ No ☐

MEDICAL QUESTIONNAIRE

Dear parents/guardian,

We ask about these medical conditions as they can impact on a child's dental health care we provide. We realized some of these questions are very personal. Please provide to the best of your knowledge.

I have personal information that I do not wish to write down. I would prefer to speak confidentially with a dental staff member about this.

Please tick in the box if this applies ☐

**Please tick as appropriate*

	Yes	No
Does your child have any allergies? *This includes food, medicines and/or products e.g. latex gloves, band-aids, colophony, rosin, milk protein-casein* *If yes, give details :*		
Has your child been admitted to the hospital before or in the last 6 months? *If yes, give details:*		
Is your child currently taking any medications? *If yes, give details:*		
Does your child have any conditions or disabilities we need to consider when we provide his/her treatment? (physical, sensory, intellectual ,psychological) *If yes, give details:*		