Non Consent / Withdrawal from Service

ONLY FILL THIS SIDE IN IF YOU DO NOT GIVE CONSENT

☐ I do not consent for my child / children to have any care as provided by the School Dental Service.

☐ I wish to withdraw my child / children from the School Dental Service.

- I accept that the Dental Therapist and their employer cannot be held responsible for any condition, which may arise as a consequence of my refusal of giving my consent.
- I understand that dental care provided for my child by a private dental practitioner would be ***at my own expense***.

ONLY FILL THE BELOW IN IF YOU DO NOT GIVE CONSENT

Name of Child / Children:

.....

.....

.....

.....

....

Signature Please print your name Date

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

Community Dental Clinic
MIS Grounds
Intermediate Street
Masterton 5810

Ph: 06 377 9071
Fax: 06 377 9072
Mobile: 027 264 4322
Email:
oralhealth@wairarapa.dhb.org.nz

ENROLMENT FOR ORAL HEALTH SERVICE

The School Dental Service provides free dental examinations and care for children from birth to the end of Year 8. It has commitment to informing patients / parents of treament options.

CHILD .....

Surname First Name(s)

CHILDS NHI NUMBER .....

PARENT/S / CAREGIVER/S

.....

Surname First Name/s

.....

Surname First Name/s

Current School .....

Previous School / Pre-school .....

DOB ..... **Male / Female**

ADDRESS .....

.....

PH: Home..... **Mobile** .....

PH: Work: .....

ALTERNATIVE CONTACT: **Name**.....

Phone .....**Relationship to child**.....

MEDICAL HISTORY

This information is kept confidential

Does your child have any disabilities eg hearing, sight, speaking, physical or mental health, learning or remembering?

.....

Some medical conditions and some medicines affect dental care. Please answer the question below:
Has your child ever had?

		Yes	No
☞	Bleeding trouble	❑	❑
☞	Rheumatic Fever	❑	❑
☞	A Heart Condition	❑	❑
☞	* requires antibiotics for dental treatment	❑	❑
☞	Diabetes	❑	❑
☞	Epilepsy	❑	❑
☞	Hepatitis A	❑	❑
☞	B	❑	❑
☞	C	❑	❑
☞	Asthma	❑	❑
☞	Has your child any other medical conditions?	❑	❑

If yes please specify: .....

☞ An allergy to medication or other substance ❑ ❑

If yes please specify: .....

☞ Name of family doctor if any: .....

☞ Is your child taking any pills or medication prescribed by a doctor? ❑ ❑

If yes please state the name of the medication (it is usually written on the bottle): .....

☞ Reason for taking medication: .....

Has your child been enrolled at any other Dental Clinic outside of the Wairarapa? ❑ ❑

If so, please give Clinic name and address:

.....

ETHNIC ORIGIN

We need the following information for health statistics only.

Which cultural heritage does your child belong to?
Please tick box that applies.

NZ Maori ❑ NZ European ❑ Pacific Island ❑

Iwi.....

Other (Please specify) .....

Please sign the following:

Enrol with the Oral Health Service for free care.

I understand my child is enrolled with the school Dental Service and will receive an **annual examination which may require an x-ray, and fluoride**. Should any further treatment be necessary my signed consent will be required.

I also give consent for my child's dental records to be passed on to subsequent dental clinics my child attends so that continuity of care can be provided.

I also give consent to the School Dental Service to obtain my child's NHI number.

....
Signature of Parent / Caregiver Date

Names of any other children (siblings):

_____ School _____ Pre-school
_____ School _____ Pre-school
_____ School _____ Pre-school
_____ School _____ Pre-school

We undertake:

- to inform you of what needs to be done to keep your child's mouth healthy
- to make you welcome at any appointment
- to take note of your particular treatment preferences