Non Consent / Withdrawal from Service

- ❑ 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***.

Name of Child / Children:

.....

.....

.....

.....

…… …….. ……

Signature Please print your name Date

Community Dental Clinic
MIS Grounds
Intermediate Street

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

ENROLMENT FOR ORAL HEALTH SERVICE

The School Dental Service provides free dental examinations and care. 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 ....

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

ADDRESS .....

.....

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

PH: Work: .....

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

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

PLEASE TURN OVER

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 ❑

Other (Please specify) .....

Please sign the following:

Enrol with the Dental Therapist for free care.

I understand my child is enrolled with the school Dental Service and will receive an annual examintation. 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**

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

MEDICAL HISTORY

This information is kept confidential

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 Dental Clinic? ❑ ❑

If so, please give Clinic name and address:

.....

PLEASE TURN OVER