W&L MOBILE HEALTHCARE services

# STUDENT CONSENT FORM

**School Name:** ______________________ Year level: __________ Class: _______________

**Personal Details**

First Name: ________________ Surname: ________________ **DOB:** ________________

Gender: Male / Female (Please circle)

Medicare Number: _______________________ Reference Number: _____________________

☐ I would like mobile dentistry services to be delivered to my child at school (If yes, complete below)
☐ I do not require mobile dentistry services to be delivered to my child at school (If no, do not complete below or next page)

**Parent/Guardian/Emergency Contact**

Name: ________________ Relationship: ________________ Phone: ________________

Address: _________________________________ Email: ____________________

**Medical Practitioner**

Name: ________________ Phone: ________________

Practice Address/ Name (if known): _________________________________

**Medical Details**
Are you of Aboriginal or Torres Strait Islander descent? Yes/ No (Please circle)
Allergies (Please list all including medications)

______________________________________________________________________

______________________________________________________________________

Have you ever had treatment for cancer? (Including radiotherapy to the head/neck area) Yes/ No (Please circle)
Please tick if you have/had any of the following medical conditions

| **Heart Problems** | | **Chronic Conditions** | | **Infectious Diseases** | | **Other** | |
|---|---|---|---|---|---|---|---|
| High blood pressure | ☐ | Diabetes | ☐ | Tuberculosis | ☐ | Epilepsy | ☐ |
| Bleeding disorder | ☐ | Asthma | ☐ | Hepatitis A, B, C | ☐ | Kidney disorder | ☐ |
| Artificial heart valve | ☐ | | | | | | |

Are you currently being treated for any condition by a Doctor/Psychologist/Health Worker? Yes / No (Please circle)

Please list all tablets/capsules/injections/medications or other drugs you are currently taking

______________________________________________________________________

______________________________________________________________________

Do you have any conditions or disabilities that may affect your treatment? (Please list)

______________________________________________________________________

______________________________________________________________________

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Please list any operations that you have had

______________________________________________________________________________________

______________________________________________________________________________________

**Declaration**

I have completed the questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place my child at undue medical risk or compromise their treatment:

**Parent/Guardian signature:** ________________________________ **Date:** ____________________