

STUDENT CONSENT FORM

School Name: _____ Year level: _____ Class: _____

Students Personal Details

Surname: _____ Birth Name: _____ DOB: __ / __ / ____

Gender: Male / Female (Please circle)

Medicare Number: _____ Reference Number: __ EXP: __ / ____

I give consent to W&L Mobile Dentistry to perform Comprehensive Oral Exam, Scale & Clean, Flouride Treatment, Hygiene Education and X-Rays if needed, to my child at school? Yes/ No (Please circle)

I would you like to attend my child's appointment? Yes/ No (Please circle)

Are you of Aboriginal or Torres Strait Islander descent? Yes/ No (Please circle)

Parent/Guardian/Emergency Contact

Full Name: _____ Relationship: _____ Phone: _____

Address: _____ Email: _____

Medical Practitioner

Doctors Name: _____ Phone: _____

Practice Address/ Name (if known): _____

Medical Details

Please tick if you have/had any of the following medical conditions

Heart Problems	Chronic Conditions	Infectious Diseases	Other
High blood pressure <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>	Epilepsy <input type="checkbox"/>
Bleeding disorder <input type="checkbox"/>	Asthma <input type="checkbox"/>	Hepatitis A, B, C <input type="checkbox"/>	Kidney disorder <input type="checkbox"/>
Artificial heart valve <input type="checkbox"/>	Cancer <input type="checkbox"/>	Other (specify) _____ <input type="checkbox"/>	

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

Please list all details of medical conditions of concern (not listed), prescribed and over the counter medications or other drugs you are currently taking.

Allergies (Please list all including medications)

Are you allergic to anything e.g. local anesthetic, latex, penicillin, peanut etc. (please specify)

PTO

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

Please list any operations that you have had in the past 12 months.

Declaration

I have accurately completed this pre-clinical 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.

I hereby give my authority for any treatment agreed upon by me, to be carried out by W&L Mobile Healthcare dentists and their staff and I assume full financial responsibility for treatment when my child's CDBS (Child Dental Benefit Scheme) limit is reached.

Parent/Guardian Signature: _____

Date: _____