Darling Downs Health

Registration for a child to attend Darling Downs Health School Dental Service (Medicare information and medical history)

Date: / /

ALL INFORMATION ON THIS FORM IS STRICTLY CONFIDENTIAL

DO NOT WRITE IN THIS BINDING MARGIN

CHILD'S DETAILS

Family name:

Given name(s):

Date of birth: / /

Sex: ☐ Male ☐ Female ☐ Indeterminate

Country of birth:

Language spoken at home:

Interpreter required? ☐ Yes ☐ No

Indigenous status:
- ☐ Aboriginal but not Torres Strait Islander origin
- ☐ Torres Strait Islander but not Aboriginal
- ☐ Both Aboriginal and Torres Strait Islander
- ☐ Not Aboriginal or Torres Strait Islander
- ☐ Not stated / unknown

Australian South Sea Islander status: ☐ Yes ☐ No ☐ Not stated / unknown

School: **Year:**

Child's Medicare number:

IRN: *The IRN is the number which appears next to your child's name.* Expiry: MM / YYYY

Child's Pension / Health Care Card number:

CRN: *The CRN is the number which appears next to your child's name.* Expiry: MM / YYYY

Child's doctor:

Name:

Address:

Phone:

Is child currently under treatment? ☐ No ☐ Yes

If 'Yes' details:

CHILD'S MEDICAL HISTORY

List current medications and dosages *(including non-prescription)*

List any allergies *(e.g. latex, penicillin, dairy, silver)*

MEDICAL HISTORY *continued*

Has your child ever been hospitalised or had an operation under general anaesthetic?
☐ No ☐ Yes ▸

Has your child ever had a problem with anaesthetic – local or general?
☐ No ☐ Yes ▸ *Details:*

Does you child require antibiotic cover for dental treatment?
☐ No ☐ Yes ▸ *Details:*

Dental history	☐ Anxiety ☐ Trauma ☐ Orthodontic treatment ☐ General anaesthetic ☐ Other:	*Details:*
Female only	☐ Pregnant	Weeks:
Family & social history	☐ Smoker ☐ Alcohol ☐ Recreational drugs	*Details:*
Mental health	☐ Yes ☐ No	*Details:*
Disability	☐ Physical ☐ Sensory ☐ Intellectual ☐ Non-verbal ☐ Vision/hearing impaired ☐ Wheelchair	*Details:*
Behavioural condition	☐ ADHS / ADD ☐ ASD	*Details:*
Kidney problems	☐ Yes ☐ No	*Details:*
Heart condition	☐ Yes ☐ No	*Details:*
Respiratory	☐ Asthma / bronchitis ☐ Other:	*Details:*
Central Nervous System	☐ Yes ☐ No	*Details:*
Developmental conditions	☐ Yes ☐ No	*Details:*
Hormonal conditions	☐ Yes ☐ No	*Details:*
Stomach disorders	☐ Yes ☐ No	*Details:*
Blood conditions	☐ Yes ☐ No	*Details:*
Liver conditions	☐ Yes ☐ No	*Details:*
Infectious conditions	☐ Yes ☐ No	*Details:*
Musculo-skeletal syndromes	☐ Yes ☐ No	*Details:*
Cancer treatment	☐ Yes ☐ No	*Details:*

I have confidential medical information about my child that I wish to speak to a dental practitioner about *(please tick if appropriate)*

Parent/guardian to confirm medical history is true and correct:

Name:

Signature: Date: / /

v1.00 - 10/2020
00104:38bnb

Please turn over to complete parent/carer details and consent ▸

Dear Parent/Guardian,

Southern Downs Oral Health Services will soon be offering treatment to children attending SCOTS PGC College.

Treatment will be provided at: Dental Van on school grounds at Warwick State High School, Warwick.

However, if wheelchair access is required, appointments may be at Warwick Dental Clinic.

You may register your child for a check-up by completing this form and returning it to the school office no later than: 21/08/2023

Your contact details and Medicare card (*blue or green) information for the children you wish to register are required to begin the process *(*your child must be named on a Medicare card to be eligible)*. You must also complete the medical history on the front of this form.

Registration and access to treatment is for a limited time. Non-emergency treatment outside of this treatment offer may be sought in the private sector.

PARENT/CARER DETAILS

Family name:
Given name(s):
Home address:
Postcode:
Relationship to child/children:
Phone (H):
Phone (W):
Phone (M):
Email:

Please note:

- Parents/Legal Guardians **must** attend **all** appointments.
- Darling Downs Health does not accept any responsibility for the transport of children **to** and **from** their appointments.

If you have other children, they may also be eligible for treatment (conditions apply). Please indicate below.

- ☐ Yes 4 year-old child, not yet at school
- ☐ Yes 2 & 3 year-old children*
- ☐ Yes children at school (prep-grade 10)
- ☐ Yes children in grades 11-12*

If CDBS eligible, benefit **must be utilised. Please ask us for more details.*

- Staple all completed forms of family members together when handing them in.

CONSENT – Please tick 'Yes' or 'No' to each statement and sign below.

I consent to my child receiving the following:

- a dental examination – including dental xrays if considered necessary as part of the examination
- preventive oral care if considered necessary, such as oral health education, cleaning of teeth and the application of enamel strengthening/remineralising agents (e.g. fluoride) to the teeth.

I understand that the examination (and associated procedures deemed necessary may involve more than one appointment and that separate consent will be required should further treatment be recommended.

☐ **Yes, I consent** ☐ **No, I do not consent**

I consent to other health professionals being consulted where it will assist in the provision of my child's oral health care.

☐ **Yes, I consent** ☐ **No, I do not consent**

I consent to health professionals who have treated my child exchanging such information about my child as may be required to assist in providing oral health care to my child. I also consent to information that has been collected by the Department of Health, in the course of my child's oral health care, being used by the Department of Health to check and asses the oral health services my child has received and how such services have been used, provided my child's name is not used in any reports or published statistics.

☐ **Yes, I consent** ☐ **No, I do not consent**

I consent for a representative of the Department of health to contact me via the details I have provided regarding oral health services. This includes texting to the mobile number provided.

☐ **Yes, I consent** ☐ **No, I do not consent**

Name:	Signature:
Relationship to child:	Date: / /

OFFICE USE ONLY

Checked by clinician: ☐ CDBS ☐ Authority to care letter

DO NOT WRITE IN THIS BINDING MARGIN

Privacy Statement

Personal information collected by Queensland Health from patients is handled in accordance with the *Information Privacy Act 2009* and the *Hospital and Health Boards Act 2011.* Your personal information is being collected by way of this form to provide you with oral health services. The personal information provided by you will be securely stored and made available to appropriately authorised staff of Queensland Health. Your personal information may also be disclosed to health practitioners who have in the past or will provide you with care or treatment, to staff of Queensland Health for the purpose of conducting assessment of the services provided to you or otherwise for the purpose relating to providing you with public sector health services. Personal information recorded on this form will not be used or disclosed to other parties without your consent, unless authorised or required by law. For information about how Queensland Health protects your personal information, or to learn about your right to access your own personl information, please see our website at www.health.qld.gov.au

Darling Downs Health

Thank you for registering your child to be seen by the Darling Downs Oral Health Service. If you have other children you wish to be seen by us please complete the registration areas below and on the other side of this form.

Who can you register?

You can register your child if they are:

- Attending another Primary or Secondary school and in years Prep to end of grade 10
- In years 11& 12 but must be eligible for the Medicare Dental Benefits Schedule
- Home Schooled
- Not at school but 4 years old
- 0-3 years old and eligible for the Medicare Dental Benefits Schedule

Please complete below if you have other children you wish to be seen.

Child Two

Family/Last Name(s)			***Date of Birth*** / /
First Name(s)			**Male** ❍ **Female** ❍
School		**Grade**	
Language		**Country of Birth**	
Indigenous Status			
☐ Aboriginal but not Torres Strait Islander		☐ Torres Strait Islander but not Aboriginal	
☐ Both Aboriginal and Torres Strait Islander		☐ Not Aboriginal or Torres Strait islander	
Australian South Sea Islander status			
☐ Yes ☐ No			
Medicare Number		**Line No.**	**Expiry date** /

Child Three

Family/Last Name(s)			***Date of Birth*** / /
First Name(s)			**Male** ❍ **Female** ❍
School		**Grade**	
Language		**Country of Birth**	
Indigenous Status			
☐ Aboriginal but not Torres Strait Islander		☐ Torres Strait Islander but not Aboriginal	
☐ Both Aboriginal and Torres Strait Islander		☐ Not Aboriginal or Torres Strait islander	
Australian South Sea Islander status			
☐ Yes ☐ No			
Medicare Number		**Line No.**	**Expiry date** /

PLEASE TURN OVER TO REGISTER MORE CHILDREN

Queensland Government

Child Four

Family/Last Name(s)			***Date of Birth*** / /
First Name(s)			**Male** ❍ **Female** ❍
School		**Grade**	
Language		**Country of Birth**	
Indigenous Status			
☐ Aboriginal but not Torres Strait Islander		☐ Torres Strait Islander but not Aboriginal	
☐ Both Aboriginal and Torres Strait Islander		☐ Not Aboriginal or Torres Strait islander	
Australian South Sea Islander status			
☐ Yes ☐ No			
Medicare Number		Line No.	Expiry date /

Child Five

Family/Last Name(s)			***Date of Birth*** / /
First Name(s)			**Male** ❍ **Female** ❍
School		**Grade**	
Language		**Country of Birth**	
Indigenous Status			
☐ Aboriginal but not Torres Strait Islander		☐ Torres Strait Islander but not Aboriginal	
☐ Both Aboriginal and Torres Strait Islander		☐ Not Aboriginal or Torres Strait islander	
Australian South Sea Islander status			
☐ Yes ☐ No			
Medicare Number		Line No.	Expiry date /

Child Six

Family/Last Name(s)			***Date of Birth*** / /
First Name(s)			**Male** ❍ **Female** ❍
School		**Grade**	
Language		**Country of Birth**	
Indigenous Status			
☐ Aboriginal but not Torres Strait Islander		☐ Torres Strait Islander but not Aboriginal	
☐ Both Aboriginal and Torres Strait Islander		☐ Not Aboriginal or Torres Strait islander	
Australian South Sea Islander status			
☐ Yes ☐ No			
Medicare Number		Line No.	Expiry date /