Health History/Consent for Treatment

Please complete this 2 page form and SIGN as parent or guardian ON BOTH PAGES. This completed form and a reservation is needed to participate. "Give Kids A Smile" provides free, comprehensive dental care – including examinations, professional cleanings, sealants, fillings, and extractions.

School Name: _____

Address: _____

City: _____ ZIP: _____

School Nurse or Contact Person:

Name: _____ Phone: _____

Email: _____@_____ Fax #: _____

To Be Completed by Parent or Guardian – Information about your child

Child's Name: First _____ **MI** ____ **Last** _____

Child's Date of Birth _____ **Child's Gender:** Male _____ Female _____

Home Address _____
Street City Zip Code

Home Phone _____ **Cell/Mobile Phone** _____

Name of Parent/Guardian: _____

Child Lives With: ____ Check if same as above

Name: First: _____ MI _____ Last _____

Address: _____

City: _____ State _____ ZIP _____

Home Phone: _____ Cell Phone: _____

IN CASE OF EMERGENCY CONTACT:

Name: First: _____ MI: _____ Last: _____

Address: _____

City: _____ State: _____ ZIP: _____ **Phone:** _____

Who should we contact on the day of service to discuss your child's care?

Name: First: _____ MI: _____ Last: _____

Address: _____

City: _____ State: _____ ZIP: _____

I give consent for my child to participate in the free preventive and restorative dentistry program conducted by the Give Kids a Smile- Quincy program, known as GKAS. To the best of my knowledge, the medical history questions on page 2 have been answered correctly and accurately. I allow my child to receive a visual assessment prior to the treatment day, local anesthetic (numbing of the mouth), dental treatment, and to be photographed while participating, understanding that the photos may be used in future educational and/or promotional material. I understand that the GKAS personnel will honor the rights of patients regarding their protected health information, but acknowledge that rare exceptions will dictate that GKAS disclose only that information needed to accomplish the intended dental treatment in a safe and healthy manner.

Name of Parent/Guardian (Printed) _____

Signature _____ **Date** _____

Medical History

Although dental personnel primarily treat the area in and around your mouth and face, your mouth is a part of your entire body. Health problems that your child may have, or medication that your child may be taking, could have an important interrelationship with the dentistry your child will receive. Thank you for answering the following questions.

Is your child under a physician's care now?	☐ Yes ☐ No	If yes, explain_____
Has your child been hospitalized ?	☐ Yes ☐ No	If yes, explain_____
Has your child had a major operation?	☐ Yes ☐ No	If yes, explain_____
Has your child had a serious neck or head injury?	☐ Yes ☐ No	If yes, explain_____
Is your child taking any medications, pills or drugs?	☐ Yes ☐ No	If yes, explain_____

Is your child allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain_____

Does your child have, or have they had, any of the following?

☐ AIDS/HIV Positive	☐ Cancer	☐ Fainting Spells/dizziness	☐ Kidney Problems
☐ Artificial Heart Valve	☐ Congenital Heart Disorder	☐ Heart Murmur	☐ Liver Disease
☐ Artificial Joint	☐ Convulsions	☐ Heart Trouble	☐ Lung Disease
☐ Asthma	☐ Diabetes	☐ Hemophilia	☐ Renal Dialysis
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Rheumatic Fever
☐ Breathing Problem	☐ Excessive Bleeding	☐ Hepatitis B or C	

Has your child ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain:_____

_____

_____

_____

Once you return this form to the school nurse, if an appointment is available you will be contacted by GKAS personnel.

To the best of my knowledge, the questions on this Medical History Form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform Give Kids A Smile of any changes to my child's medical status.

Signature of Parent/Guardian_____**Date:**_____