DENTAL ENROLMENT FORM

DENTAL THERAPY CENTRE
C/ - SWANBOURNE PRIMARY SCHOOL
NARLA ROAD
SWANBOURNE WA 6010 (D.200)
PHONE: 9384 0855

WOULD YOU PLEASE RETURN THIS FORM TO SCHOOL AS SOON AS POSSIBLE.

TO ENROL YOUR CHILD PLEASE COMPLETE PARTS A & B ONLY.

IF YOU DO NOT WISH TO ENROL YOUR CHILD PLEASE COMPLETE PARTS A & C ONLY.

IF YOUR CHILD IS PRESENTLY/PREVIOUSLY ENROLLED IN THE W.A. SCHOOL DENTAL SERVICE, THE TRANSFER OF DENTAL RECORDS CAN BE ARRANGED. PLEASE COMPLETE PARTS A & B OVERLEAF.

ENROLMENT SECTIONS ARE OVERLEAF

- The **School Dental Service** provides a free and continuing dental service for each enrolled school child extending to approved high school years.
- **Dental Therapy Centres** are staffed by Dental Therapists and Dental Assistants and are supervised by Dentists with the School Dental Service. You are invited to visit the Centre to discuss the treatment plan for this child. Children are recalled periodically for re-examination and any necessary treatment.
- The Dental Therapy Centre is located at the address noted above. When the patient attends a school other than where the Dental Therapy Centre is located, **it is the responsibility of the parent/guardian to transport the patient to the appointment.**
- **Each enrolled child** is taught the proper care of teeth and gums. Routine preventive therapy includes the application of fluoride preparations to the teeth, and in some cases protective coverings to permanent teeth.
- **The treatment** provided may include injections of local anaesthetics to allow painless drilling of the teeth prior to the placing of appropriate permanent or temporary fillings. Badly decayed teeth may have the nerves treated before fillings are placed. X-rays are used for diagnostic purposes only. The parent/guardian will be informed of any extractions before the teeth are extracted.
- If your child is presently having dental treatment from a **private dentist**, please wait until the completion of the current course of treatment before enrolling at the Dental Therapy Centre.
- A child may be **withdrawn** from enrolment in the School Dental Service on written instructions from the parent/guardian.
- **Specialist and general anaesthetic services** are not available, but parents are informed if such treatment is considered advisable, and an appropriate referral is made. Parents are responsible for the cost of these services.

Teeth injured in accidents at sport, etc., **may** require specialist treatment not available at the Centre. Parents are responsible for costs of such treatment. School Insurance is advisable to cover the costs.

Please complete Part A and then either **Part B or Part C** on the other side of this form and return it so that a second form is not sent to you. Any required treatment cannot be commenced until this form has been completed and returned to the school or Dental Therapy Centre.

This form **should not be altered** in any way by entering comments or amendments. Please discuss any specific concerns with the dental staff.

Please see next page

DENTAL ENROLMENT FORM

PLEASE COMPLETE PART A
PLEASE THEN COMPLETE EITHER PART B OR PART C
FURTHER INFORMATION IS OVERLEAF

PLEASE DO NOT MAKE ANY AMENDMENTS TO THIS FORM

PART A

(Please use block letters)

CHILD'S SURNAME..... PREVIOUS SURNAME..... (if applicable)

Christian or Given names ..... M or F ☐

DAY MONTH YEAR

Child's Date of Birth ☐☐ ☐☐ ☐☐☐☐ Child's Present Age ☐☐ Years

School..... Year..... Room No.....

PART B (CONSENT)

FOR ENROLMENT PLEASE COMPLETE ALL OF PART B
PLEASE TICK AND SIGN

YES ☐ ***I hereby consent to treatment, including the treatment described on the reverse of this form, of this child, by the School Dental Service in such a manner and on such occasions as the School Dental Service considers appropriate for good dental health.***

Parent's/Guardian's Signature.....Date.....

Father's Name .....

Mother's Name .....

Guardian's Name (if applicable) .....

Parents/Guardian's Address .....Postcode.....

☎ Home .....

☎ Work (Father) .....

☎ Work (Mother) .....

If you are not on the phone please give the number of a relative or neighbour

....

Name Telephone Number

	Yes or No
Has your child previously attended THIS dental therapy centre?	☐
Has your child attended another school dental therapy centre in Western Australia?	☐

If yes (1) What is the name of the last centre attended in W.A.? .....

(2) What is the name of the last school attended in W.A.? .....

Names of other school children (same family) for enrolment at this centre

Name	Year	Name	Year
.....	.....	.....	.....
.....	.....	.....	.....

NOW PLEASE COMPLETE THE ATTACHED MEDICAL HISTORY FORM.

PART C (NON CONSENT)

PLEASE TICK AND SIGN

NO ☐ I do not wish to enrol this child in the School Dental Service

Parent's/Guardian's Signature.....Date.....

PLEASE RETURN THIS FORM TO SCHOOL AS SOON AS POSSIBLE.