# DENTAL HEALTH SERVICES
# SCHOOL DENTAL SERVICE

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

# MEDICAL HISTORY FORM

**PLEASE NOTE THAT ANY TREATMENT REQUIRED CANNOT BE COMMENCED UNTIL THIS FORM HAS BEEN COMPLETED AND RETURNED TO THE SCHOOL / DENTAL THERAPY CENTRE. THIS IS A LEGAL REQUIREMENT FOR EACH NEW COURSE OF TREATMENT.**

Dear Parent/Guardian

.....will be/is enrolled at the abovementioned
Child's FULL Name

Dental Therapy Centre on a continuous basis and will be recalled at regular intervals. As we require up to date information about his/her health would you please complete the following details and return the form to the school or Dental Therapy Centre.

Parent's/Guardian's Address.....

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

Telephone Home.....Telephone Work (Father).....

Telephone Work (Mother).....

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

.....
Name Telephone Number

Name of your Family Doctor.....Telephone.....

Doctor's Address.....

**PLEASE TURN OVER →**

**PLEASE ANSWER ALL QUESTIONS WITH YES, NO OR UNKNOWN.**
**TICK THE APPROPRIATE ANSWER - IF 'YES', PLEASE COMPLETE 'DETAILS' COLUMN.**

| Has your child had:- | YES | NO | UNKNOWN | DETAILS |
|---|---|---|---|---|
| 1 Hepatitis eg Type A, B or C etc | | | | Type When |
| 2 Rheumatic Fever | | | | |
| 3 Diabetes | | | | |
| 4 Any heart complaint | | | | Type |
| 5 Epilepsy | | | | |
| 6 Asthma requiring medication | | | | What medication |
| 7 Steroid Treatment (eg Cortisone) | | | | Oral or injection When |
| 8 History of excessive bleeding | | | | |
| 9 Any serious illness/syndrome/disability | | | | |

| Is your child: | YES | NO | UNKNOWN | DETAILS |
|---|---|---|---|---|
| 1 Receiving medical treatment | | | | |
| 2 Taking any medicine or drug | | | | Type |
| | | | | Reason |
| 3 Allergic to any medicine or drug | | | | Type |
| 4 Allergic to local anaesthetic | | | | |
| 5 Receiving other dental treatment | | | | Where |
| 6 Attending an Orthodontist | | | | Orthodontists name |

**FURTHER MEDICAL DETAILS**

***DETAILS ARE CORRECT/HAVE BEEN AMENDED*** *(Please amend if necessary)*

| DATE | PARENT'S SIGNATURE |
|---|---|
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