

PLEASE FILL IN AND RETURN THIS FORM TO THE SCHOOL DENTAL CLINIC OR SCHOOL OFFICE

The information you give us about your child will be kept by the Auckland Regional Dental Service and may be shared with other health professionals. Use of and access to the information is covered by the Health Information Privacy Code. If you want to see this information or control any details contact the Auckland Regional Dental Service on 09 300 4121 DENTAL (0800 438 682).

Child's First Name Child's Middle Name(s)

Child's Family Name (Last Name) Also Known As

Child's Date of Birth day month year Male Female

Street Address

Suburb

Town/City Post Code

Home Phone Work Phone Mobile Phone

Email Address

Your Family Doctor's Name

Medical Practice

Family Doctor's Phone

National Health Index Number (if known)

School/Education Institution Attended

School Year

Is this child a NZ resident? Yes No

Ethnicity
Which ethnic group does this child belong to?
Mark the space or spaces that apply

New Zealand European
 Māori
 Samoan
 Cook Island Māori
 Tongan
 Niuean
 Chinese
 Indian
 Other (Such as DUTCH, JAPANESE, TOKELAUAN). Please state:

If you want your child to be seen by the Auckland Regional Dental Service please complete and sign the GREEN agree sections

If you DO NOT want your child to be seen by the Auckland Regional Dental Service please complete and sign the ORANGE do not consent sections

CONSENT (AGREE)

MEDICAL HISTORY
Some medical conditions and some medicines can affect dental care. To help us take good care of your child and ensure their safety please let us know if your child has suffered from any of the following:

Rheumatic Fever Yes No

Heart Conditions Yes No

Bleeding Conditions Yes No

Asthma Yes No

Epilepsy Yes No

Latex Allergy (rubber) Yes No

Other Conditions/ Allergies

Medications

CONSENT FOR SERVICES PROVIDED

I **AGREE** to this child receiving regular dental examinations. I understand that I have the right to change this consent at any time.

Any additional treatments will require further consent.

Print Family Name Today's Date day month year

Print First name Relationship to Child: Mother Father Legal Guardian

Signature

DO NOT CONSENT (DO NOT AGREE)

I **DO NOT AGREE** to this child receiving dental services from the Auckland Regional Dental Service.

Print Family Name Today's Date day month year

Print First name Relationship to Child: Mother Father Legal Guardian

Signature

Tooth decay is a preventable disease. Together we can care for your child's teeth. Here are some ways you can help:

USE FLUORIDATED TOOTHPASTE

BRUSH TEETH AT LEAST TWICE A DAY

FLOSS ONCE PER DAY

CHOOSE SUGAR-FREE SNACKS AND DRINKS

CHOOSE WATER FIRST

0800 4 DENTAL (0800 4 336825)

Auckland Regional Dental Service, Waitakere Hospital
Private Bag 93-115, Henderson, Auckland

ARDS

ENROL YOUR CHILD

**Auckland Regional
Dental Service**

Free School Dental Service

ENROLLMENT FORM



A Smile Lasts a Lifetime



Waitemata
District Health Board
Te Wai Awhina