DENTAL SCREENING CONSENT FORM

CHILD'S DETAILS

First Name:		Family Name:		
Date of Birth:		Gender:		
Address:			Postcode:	
Suburb:		Home Phone:		
Work Phone:		Mobile Phone		

Indigenous Status:	☐Neither Aboriginal or Torres Strait Islander	☐Torres Strait Islander but not Aboriginal	☐Aboriginal but not Torres Strait Islander	☐Both Aboriginal and Torres Strait Islander
Country of Birth:				
Card Type:	☐Non card holder	☐Health Care Card	☐Pension Concession Card	
Card Number:		Expiry Date:	/ /20	
Kindergarten or School Name:			Class:	
Any Medical Condition? Taking Any Medication? Any Allergies?	☐No ☐Yes: ____ ☐No ☐Yes: ____ ☐No ☐Yes: ____			

DECLARATION

I am the legal guardian of this child: ☐Mother ☐Father ☐Legal Guardian

I consent to Dental Professionals from Bass Coast Health to perform a dental screening exam on my child.

Name: ______________________________

Signature: ____________________ Date: / /

Please fill this form with your child's current details and return to Kindergarten or School within 7 days