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

Please write any comments for the Therapist here

Office Use:

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 correct any details contact:

0800 TALK TEETH (0800 825 583)

Auckland Regional Dental Service

Private Bag 93-115, Henderson 0650, Auckland

Website: www.ards.co.nz

Email: ards@waitematadhb.govt.nz

ARDS 084 June 2012

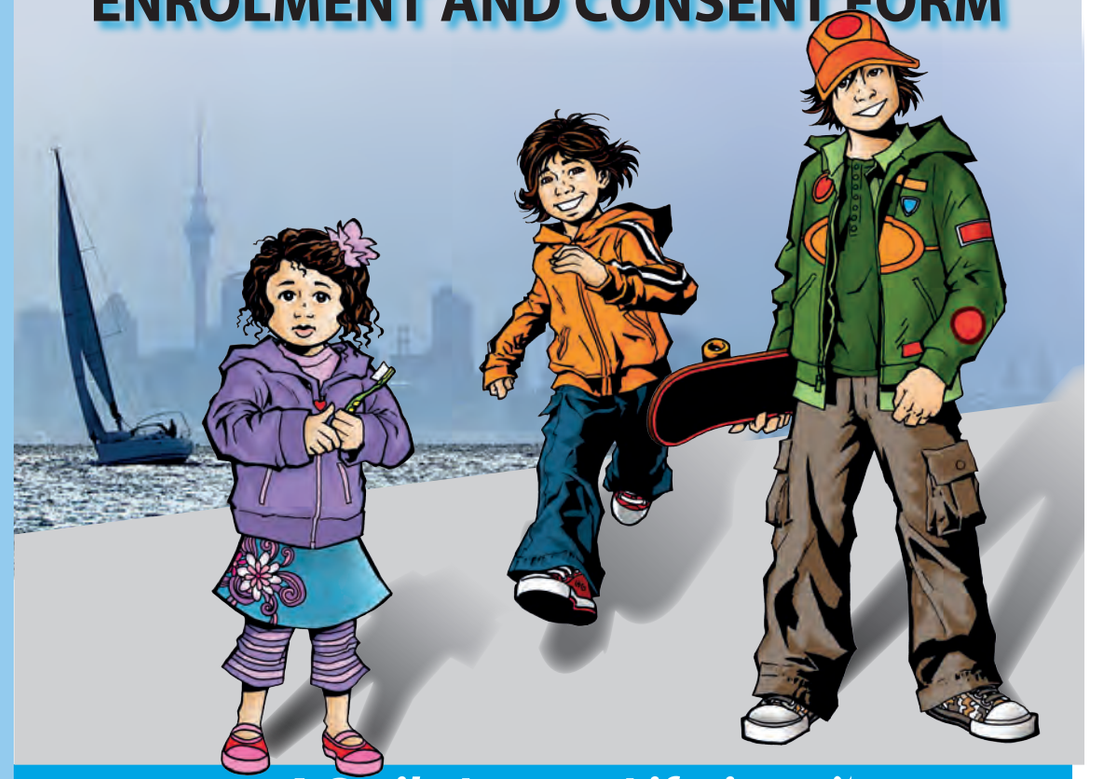
ARDS

ENROL YOUR CHILD FOR FREE

Auckland Regional Dental Service

Free *Community Dental Service*

ENROLMENT AND CONSENT FORM



A Smile Lasts a Lifetime

Waitemata District Health Board

Te Wai Awhina

0800 TALK TEETH (0800 825 583)

Website: www.ards.co.nz

PARENT / GUARDIAN CONSENT FOR EXAMINATION, XRAY CLEANING, AND PREVENTIVE CARE.

Child's First Name

Child's Middle Name(s)

Child's Family Name (Last Name)

Also Known As

Male ◯ Female ◯

Child's Date of Birth

day ____ month ____ year ____

Street Address, including suburb and postcode if known

Home Phone

Work Phone

Mobile Phone (Parent/Guardian)

Email Address (Parent/Guardian)

Brother's / Sister's Name/s and Date of Birth

Name	DOB	Name	DOB
Name	DOB	Name	DOB
Name	DOB	Name	DOB

Medical Practice / Centre Attended

Current School / Preschool

Ethnicity

Which ethnic group does this child belong to?

Tick the space or spaces that apply

- ◯ New Zealand European
- ◯ Māori
- ◯ Samoan
- ◯ Cook Island Maori
- ◯ Tongan
- ◯ Niuean
- ◯ Chinese
- ◯ Indian
- ◯ Other *(Such as Dutch, Japanese etc.)*
- ◯ Fijian
- ◯ South East Asian
- ◯ Middle Eastern
- ◯ Latin American / Hispanic
- ◯ African
- ◯ Tokelauan

Please state:

Is your child eligible to receive free health care in the NZ public health system?

Yes ◯ No ◯ Don't know ◯

For information on eligibility please visit www.moh.govt.nz/eligibility or contact 0800 825 583

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

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 or is suffering from any of the following:

Rheumatic Fever	Yes ◯	No ◯	Asthma	Yes ◯	No ◯
Heart Conditions	Yes ◯	No ◯	Epilepsy	Yes ◯	No ◯
Bleeding Conditions	Yes ◯	No ◯	Latex Allergy (rubber)	Yes ◯	No ◯

Other Conditions/ Allergies

Any Medications Currently Taking

Please alert us if there are changes to any of the above.

CONSENT FOR SERVICES PROVIDED

☑

I **AGREE** to this child receiving regular:

- Examinations and dental xrays as required
- Cleaning and scaling
- Fissure Sealant
- Fluoride Varnish

I understand that I have the right to change this consent at any time.
Please ring **0800 TALKTEETH (0800 825 583)**

Any additional treatments will require further consent.

Comments

Print Family Name (Parent/Guardian)

Today's Date

day ____ month ____ 20 year ____

Print First name (Parent/Guardian)

Signature (Parent/Guardian if under 16yrs)

Relationship to Child:

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 (Parent/Guardian)

Today's Date

day ____ month ____ 20 year ____

Print First name (Parent/Guardian)

Signature (Parent/Guardian if under 16yrs)

Relationship to Child: