

Health History/Consent for Treatment



Please complete this 2 page form and SIGN as parent or guardian ON BOTH PAGES. This completed form and a reservation is needed to participate. "Give Kids A Smile" provides free, comprehensive dental care – including diagnostic exams, professional cleanings, sealants, fillings, and extractions.

School: _____

Name: _____

Address: _____

City: _____ ZIP: _____

School Nurse or Contact Person:

Name: _____ Phone: _____

Email: _____ @ _____ FAX#: _____

To Be Completed by Parent or Guardian – Information about your child

Child's Name: First _____ MI _____ Last _____

Child's Date of Birth _____ Child's Gender: _____ Male _____ Female _____

Home Address _____

Street

City

Zip Code

Home Phone _____ Cell/Mobile Phone _____

Name of Parent/Guardian: _____

Child Lives With: _____ Check if same as above

Name: First: _____ MI _____ Last _____

Address: _____

City: _____ State _____ ZIP _____

Home Phone: _____ Cell Phone: _____

IN CASE OF EMERGENCY CONTACT:

Name: First: _____ MI: _____ Last: _____

Address: _____

City: _____ State: _____ ZIP: _____ Phone: _____

Who should we contact on the day of service to discuss your child's care?

Name: First: _____ MI: _____ Last: _____

Address: _____

City: _____ State: _____ ZIP: _____

I give consent for my child to participate in the preventive and restorative dentistry program conducted by the T.L. Gilmer Give Kids a Smile program, known as GKAS. To the best of my knowledge, the medical history questions on page 2 have been answered correctly and accurately. I allow my child to receive a visual assessment prior to the clinic day, local anesthetic (numbing of the mouth), dental treatment, and to be photographed while at the clinic, understanding that the photos may be used in future educational material. I understand that the clinic and GKAS staff will honor the rights of patients regarding their protected health information, but acknowledge that rare exceptions will dictate that GKAS disclose only that information needed to accomplish the intended dental treatment in a safe and healthy manner.

Name of Parent/Guardian (Printed) _____

Signature _____ Date _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that your child may have, or medication that your child may be taking, could have an important interrelationship with the dentistry your child will receive. Thank you for answering the following questions.

- Is your child under a physician's care now? Yes No If yes, explain _____
- Has your child been hospitalized ? Yes No If yes, explain _____
- Has your child had a major operation? Yes No If yes, explain _____
- Has your child had a serious neck or head injury? Yes No If yes, explain _____
- Is your child taking any medications, pills or drugs? Yes No If yes, explain _____

Is your child allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
- Other If yes, please explain _____

Does your child have, or have they had, any of the following?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cancer | <input type="checkbox"/> Fainting Spells/dizziness | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | |

Has your child ever had any serious illness not listed above? Yes No If yes, please explain: _____

If you are filling this form out at school, no further action is needed.

If you are accessing this form privately, or from the web, you will need to forward this form to GKAS.

For reservations call: 217-228-1085 (GKAS, ask for Candy) Fax completed consent form to: 217-228-1089

Or, mail completed consent form to: GKAS, c/o Candy Miller, 4561 Maine St., Quincy, IL 62305

To the best of my knowledge, the questions on this Medical History Form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform Give Kids A Smile of any changes to my child's medical status.

Signature of Parent/Guardian _____ **Date:** _____