

Flying Doctor School Dental Program Check-up Consent Form

The Flying Doctor Dental team will be visiting your child's school to provide:

- FREE dental check-ups and;
- education about healthy teeth and gums

If you would like your child to have a dental check-up, please complete this consent form and return it to your child's school.

After your child's check-up, the dental team will send home a report. If your child requires follow-up treatment this will be in the report. Our mobile public clinic will be in town soon after and your child can have their treatment at no cost. Alternatively, you can visit your nearest public or private practice. If you require any further information, please contact Flying Doctor Dental Team on (03) 8412 0444 or dental@rfdsvic.com.au.

Child's Details

School: _____ Class/room: _____

Surname: _____ First Name: _____

Date of Birth: _____ Male Female

Address: _____ Postcode: _____

Phone number: _____ Mobile: _____

Consent

I, _____ being the legal parent/guardian

of _____ (child's name) give my consent for the following:

- | | | |
|--|---------------------------------|--------------------------------|
| 1. My child's teeth to be examined by the Flying Doctor Dental team. I give permission for the dental team to contact me, to help coordinate my child's follow up care, if needed. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |
| 2. My child's photo taken during the dental visit for promotional purposes of the Flying Doctor Dental Program. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |

Signed: _____ Date: _____

Please note: Your child can still have their teeth checked even if you have ticked 'no' to item 2. If you have provided consent for your child's to be examined please complete the second page.

RFDS Vic. complies with all Commonwealth and State privacy legislation. A copy of our Privacy Policy is available on the RFDS Vic. website www.flyingdoctor.org.au.

F5.21.03 Oral Health Screening Consent Form - Child		Version 3
Date Implemented: 12/2017	Review Date: 06/2018	Authorised by: GM Primary Health

Medical History

Does your child have any allergies (e.g. latex, food colourings)? Yes No

Does your child have any physical/sensory/intellectual disabilities? Yes No

Does your child have any medical conditions? Yes No

If yes to any of the above, please provide more information below

When was your child's last visit to the dentist? _____

Emergency Contact Details

Name: _____ Phone Number: _____

Relationship to child: _____

Additional Information

Child's country of birth: _____

Language(s) spoken at home: _____ Interpreter required? Yes / No

Does your child identify as Aboriginal or Torres Strait Islander? Yes No

Health Care Card Number (if applicable): _____ Expiry: _____

Do you have other children attending this school? Yes No

Child's name: _____

Child's name: _____

Child's name: _____

Child's name: _____

*Please fill out a separate form for each child