FONES SCHOOL OF DENTAL HYGIENE HEALTH HISTORY CONSENT FORM

I hereby give permission to the dental hygienist to provide appropriate care for my child to include; clean, apply a fluoride treatment, take radiographs, and apply sealants to the teeth of:

Name: _____ **Gender: M F** **Date of Birth:** ____/____/____
Mo Day Year

Address: _____ **Home/cell phone number:** _____

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic
☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Other

In case of emergency whom may we contact: _____ _____ _____
Name Relationship Phone number

Teachers Name: _____ **Grade:** _____ **Room:** _____

Child's insurance information: _____
HUSKY PLAN NAME AND NUMBER

Date of your child's last cleaning? _____/_____

Is your child currently taking any kind of medication? ☐ Yes ☐ No _____
Medication name(s)

Does your child need antibiotic pre-medication before dental cleanings? ☐ Yes ☐ No
If yes, what is the name/type of antibiotic prescribed? _____

Child's Physician/Clinic:_____ _____ _____
Name Address Phone number

Please check the appropriate answer for each question (Yes or No) if you child has/had any of the following conditions:

ADD/ADHD	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	Herpes	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No
Autism	☐ Yes ☐ No	Joint Replacement	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Kidney Problem	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No
Cerebral Palsy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Developmental disability	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Drug Addition	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Epilepsy/seizures	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Heart Trouble	☐ Yes ☐ No	Spinal Bifida	☐ Yes ☐ No
Hemophilia	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Hepatitis A	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No

Allergies to the following: ☐ Latex ☐ Penicillin ☐ Anesthetics ☐ Gluten ☐ Milk ☐ Other: _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:**_____