Name of child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: F / M   
Health Care #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Parents/Guardians names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **MEDICAL HISTORY** | Personal information is collected under the authority of the *ATIPP Act* for the purpose of delivering services offered by the Project. It is important for your child’s safety that you provide an accurate medical history. All information provided will be held in strict confidence by the Project. |

**Is your child…**

|  |  |  |  |
| --- | --- | --- | --- |
| - presently under a doctor’s/nurse’s care for any illness? | Yes | No | Don’t know |
| - taking medicine now? | Yes | No | Don’t know |
| Has your child been hospitalized for any illness? | Yes | No | Don’t know |

**Has your child ever had…**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| a bad reaction to dental treatment? | Yes | No | Don’t know |  | diabetes? | Yes | No | Don’t know |
| a communicable disease e.g. tuberculosis? | Yes | No | Don’t know | kidney disease? | Yes | No | Don’t know |
| heart disease? | Yes | No | Don’t know | thyroid disease? | Yes | No | Don’t know |
| abnormal bleeding? | Yes | No | Don’t know | epilepsy? | Yes | No | Don’t know |
| liver disease e.g. hepatitis, jaundice? | Yes | No | Don’t know | asthma? | Yes | No | Don’t know |
| allergies e.g. food, medicine, latex, bees,  band-aids, stickers, pine tree sap? | Yes | No | Don’t know | cancer e.g. leukemia? | Yes | No | Don’t know |
| Has your doctor/nurse advised you that your child requires antibiotics before surgery or dental treatment? | | | | | | Yes | No | Don’t know |

If you answered **Yes** to any of these questions or if your child is currently being investigated for a health condition or has any conditions or diseases not listed above, please explain.  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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I consent to the dental therapist/dental hygienist contacting our nurse or family doctor in order to obtain more information on medical conditions noted above. ☐ Yes

**I DO NOT CONSENT** to my child being enrolled in the Nunavut Children’s Oral Health Project.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 SIGNATURE OF PARENT / GUARDIAN DATE

**I CONSENT** to my child receiving fluoride varnish application at **which time, brushing and flossing instructions** may be provided.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 SIGNATURE OF PARENT / GUARDIAN DATE

If you have any questions or concerns about this form, please contact your dental therapist or the Community Oral Health Coordinator (COHC)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or Vinay Pilly , Manager – Nunavut Children’s Oral Health Project at (867) 975-5778.

**Please sign and return this consent form to the COHC:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Name