

School Dental Health Program

Medical History

3

Student Name: _____

Date of Birth: ___/___/___

School _____ Teacher _____ Grade _____

When did your child last visit a dentist? In the past year More than a year Never

Why did your child visit the dentist?

Cleaning/checkup Toothache Filling Tooth pulled Other

Medical History: Check all that apply

Artificial Heart Valve Artificial Joints Pins/Screws Asthma Congenital Heart Disorder
 Diabetes Heart Disease Hepatitis Seizure disorder
 Heart murmur Autism Other _____

Any Known Allergies: Latex Amoxicillin/Penicillin Other _____

Is your child required by physician to take pre-medication (antibiotics) prior to dental treatment? No Yes

If yes, for what condition _____

Does your child have Special Health Care Needs? No Yes

Surgeries/Hospitalizations/Other Medical Conditions: _____

Medications your child is currently taking? _____

Other information- Please tell us anything you think we should know about your child's health or previous dental experiences that would help us treat your child or meet their needs. _____

I confirm that the above health information is accurate to the best of my knowledge and I will contact the school as soon as possible if any changes occur.

CHC/SEK will treat all patient information as protected health information (PHI) under HIPPA regulations, exchanging the PHI only with personnel employed by CHC/SEK and the facility/school who are responsible for medical treatment and/or record review.

Parent/Guardian Signature _____

Date _____



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- | | | | |
|---|--|--------------------------------------|--|
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