

Registration for a child to attend Darling Downs Health School Dental Service

All children from birth to end of grade 12 are eligible. No restrictions or out of pocket expenses.

- A new registration form must be completed for your child every year, even if we have previously seen your child.
- Only return this form if you wish for your child/ren to be seen by the School Dental Service.

ALL INFORMATION ON THIS FORM IS STRICTLY CONFIDENTIAL

Dear Parent/Guardian,

Darling Downs Oral Health Services will soon be offering treatment to children attending:

Treatment will be provided at:

If wheelchair access is required, alternative arrangements can be made. Is wheelchair access required? Yes No

You may register your child for a check-up by completing this form and returning it to the school office no later than:

Your contact details and Medicare card information for the child/ren you wish to register are required to begin the process (your child must be named on a Medicare card to be eligible).

Registration and access to treatment is for a limited time – emergency treatment outside of this treatment offer may be sought at your family dentist or by phoning the Darling Downs Oral Health Call Centre on 1300 082 662 between 8 am – 12 pm, Monday to Friday. Excluding public holidays.

Please note:

- If your child is CDBS eligible, the benefit must be utilised. Please ask us for more details.
- Parents/Legal Guardians **must** attend **all** appointments.
- Darling Downs Health does not accept any responsibility for the transport of children **to** and **from** their appointments.

CONSENT

I consent to my child/ren receiving the following:

- a dental examination – including dental xrays if considered necessary as part of the examination
- preventive oral care if considered necessary, such as oral health education, cleaning of teeth and the application of enamel strengthening/remineralising agents (e.g. fluoride) to the teeth.

I understand that the examination (and associated procedures deemed necessary) may involve more than one appointment and that separate consent will be required should further treatment be recommended.

I consent to other health professionals being consulted where it will assist in the provision of my child's oral health care.

I consent to health professionals who have treated my child exchanging such information about my child as may be required to assist in providing oral health care to my child. I also consent to information that has been collected by the Department of Health, in the course of my child's oral health care, being used by the Department of Health to check and assess the oral health services my child has received and how such services have been used, provided my child's name is not used in any reports or published statistics.

I consent to be contacted by phone, text or email from the information I have provided.

Name:	Signature:	Date: / /
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Please complete page 2 ➔

Who can you register? Any child from birth to end of Year 12.

PARENT/CARER DETAILS

Family name:	Doctor's details:
Given name(s):	Doctor name:
Home address:	Practice name:
Postcode:	
Phone:	
Email:	Phone number:

CHILD'S DETAILS (1)

Family name:	Language spoken at home:	Country of birth:
Given name(s):	Interpreter required? Yes No	
Preferred name(s):	Indigenous status:	
	Aboriginal but not Torres Strait Islander origin	
	Torres Strait Islander but not Aboriginal	
	Both Aboriginal and Torres Strait Islander	
	Not Aboriginal or Torres Strait Islander	
	Not stated / unknown	
Date of birth:	Relationship to child:	
Birth Sex: Male Female Other:		
Gender: Male Female Non Binary	Australian South Sea Islander status:	
Prefer not to answer	Yes No Not stated / unknown	
Other:		
Variations to sexual characteristics:	School:	Year:
Yes No Do not know Prefer not to answer	Child's Medicare number:	
Client pronouns:	IRN:	Expiry:
They, Them, Their, Theirs, Themselves	<i>The IRN is the number which appears next to your child's name.</i>	MM / YYYY
He, Him, His, Himself		
She, Her, Hers, Herself		
Uses other pronouns		
Unknown pronouns		
Prefer not to answer		
	Admin use only:	
	☐ CDBS checked ☐ HBCIS checked	

CHILD'S DETAILS (2)

Family name:	Language spoken at home:	Country of birth:
Given name(s):	Interpreter required? Yes No	
Preferred name(s):	Indigenous status:	
	Aboriginal but not Torres Strait Islander origin	
	Torres Strait Islander but not Aboriginal	
	Both Aboriginal and Torres Strait Islander	
	Not Aboriginal or Torres Strait Islander	
	Not stated / unknown	
Date of birth:	Relationship to child:	
Birth Sex: Male Female Other:		
Gender: Male Female Non Binary	Australian South Sea Islander status:	
Prefer not to answer	Yes No Not stated / unknown	
Other:		
Variations to sexual characteristics:	School:	Year:
Yes No Do not know Prefer not to answer	Child's Medicare number:	
Client pronouns:	IRN:	Expiry:
They, Them, Their, Theirs, Themselves	<i>The IRN is the number which appears next to your child's name.</i>	MM / YYYY
He, Him, His, Himself		
She, Her, Hers, Herself		
Uses other pronouns		
Unknown pronouns		
Prefer not to answer		
	Admin use only:	
	☐ CDBS checked ☐ HBCIS checked	