Rowan College at BURLINGTON COUNTY

Adhere medical alert sticker here if applicable

CHILD HEALTH HISTORY FORM

Date: ______/______/______

Patient's Name: ________________________________ **Preferred Name:** ________________

LAST FIRST MIDDLE INITIAL

Date of Birth: ________________ **Age:** ________________

Parent's/Guardian's Name: ________________ **Relationship to Patient:** ________________

Address: ____

STREET CITY STATE ZIP

Phone: (   ) ____________ **Type (circle):** Home Cell Work **Email:** ________________

	YES	NO	DK
Have you (the parent/guardian) or the patient had any of the following diseases or problems?.......... 1. Active Tuberculosis, 2. Persistent cough greater than 3 week duration, 3. Cough that produces blood?	☐	☐	☐

If you answered yes to any of the above 3 questions, please stop and return this form to the receptionist.

Has the child had any history of, or condition related to, any of the following?

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV/AIDS	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunization	☐ Mumps	☐ Tobacco/Drug Use
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Pregnancy	☐ Tuberculosis
☐ Bladder	☐ Sinusitis	☐ Hearing	☐ Latex Allergy	☐ Rheumatic fever	☐ Venereal Disease
☐ Bleeding	☐ Diabetes	☐ Heart	☐ Liver	☐ Seizures	☐ Other _________
☐ Bones/Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ Sickle Cell	

Please list the name and phone number of the child's physician:

Name of Physician: ________________________________ Phone: ________________

CHILD'S HISTORY

	YES	NO	DK
Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time?	☐	☐	☐
If yes, please list: ________________________________			
Does the child have any allergies? (ie. medication, antibiotics, food, etc) If yes, please explain: ____________	☐	☐	☐
How would you describe the child's eating habits? ________________________________			
Has the child ever had a serious illness or been hospitalized?..........	☐	☐	☐
Does the child have a history of or currently being treated of any illnesses? If yes, please list: ____________	☐	☐	☐
Has the child ever received a general anesthetic?..........	☐	☐	☐
Does the child have any inherited problems?..........	☐	☐	☐
Has the child ever had a blood transfusion?..........	☐	☐	☐
Is the child physically, mentally, or emotionally impaired?..........	☐	☐	☐
Does the child experience excessive bleeding when cut?	☐	☐	☐
If not the first visit, please provide the date of the last dentist visit: __________ Name of dentist: ____________			
Has the child had any problem with dental treatment in the past?	☐	☐	☐
Has the child ever had dental radiographs (x-rays) exposed?	☐	☐	☐
Has the child ever suffered any injuries to the mouth, head or teeth?	☐	☐	☐
Has the child had any orthodontic treatment?	☐	☐	☐
What type of water does your child drink? ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water			
Does the child take fluoride supplements?..........	☐	☐	☐
Is fluoride toothpaste used?	☐	☐	☐
How many times are the child's teeth brushed per day?..........	☐	☐	☐
Does the child suck his/her thumb, fingers or pacifier?..........	☐	☐	☐
Does the child participate in active recreational activities?..........	☐	☐	☐

NOTE: Both dental team and patient/guardian are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above, and that the information given on this form is accurate. I understand the importance of a truthful health history and that RCBC staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold RCBC or any other member of the staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

________________ ________________ ________ ________

Parent/Guardian's Signature *Student Signature* *Date* *Faculty*

PLEASE COMPLETE BOTH SIDES.

Treatment Consent

By law, all children under the age of 18 years cannot be treated by a doctor without consent from a parent or legal guardian. If you have any concerns about the below treatment that is provided in the RCBC Dental Hygiene clinic, you are encouraged to speak with a provider prior to the start of any appointments. By signing below, you affirm that you have read, understand, and have been given the opportunity to discuss any concerns you may have regarding dental treatment.

Patient's Name: ______________________________ **Date of Birth:** ____________________

Contact number (should an emergency arise) (   ) ______________________

I, ______________________________ consent for my minor child to have routine
PARENT/LEGAL GUARDIAN NAME

dental care completed by a dental hygiene student, which may include:

- Oral Examination
- Oral Hygiene Instructions
- X-Rays
- Dental Prophylaxis (teeth cleaning, including scaling and polishing)
- Fluoride Treatment
- Sealants, if indicated

______________________________ ______________________________
Parent or Legal Guardian (Print) Relationship

______________________________ ______________________________
Parent or Legal Guardian (Signature) Date